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REVIEW OF ADMINISTRATION REPORT ON PROSPECTIVE PAYMENT FOR SKILLED NURSING FACILITIES UNDER MEDICARE

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

APRIL 17, 1985

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REVIEW OF ADMINISTRATION REPORT ON PROSPECTIVE PAYMENT FOR SKILLED NURSING FACILITIES UNDER MEDICARE

WEDNESDAY, APRIL 17, 1985

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The committee met, pursuant to notice, at 9:30 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Bob Packwood (chairman) presiding.

Present: Senators Packwood, Dole, Chafee, Wallop, Durenberger, Symms, Grassley, Long, Baucus, and Mitchell.

[The press release announcing the hearing, and the statements of Senators Dole, Durenberger, and Grassley and a background paper prepared by the committee staff follows:]

[Press Release No. 85-006A; March 13, 1983]

SENATE COMMITTEE ON FINANCE SCHEDULES HEARING ON MEDICARE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT REPORT

Senator Bob Packwood (R-Oregon), Chairman of the Committee on Finance, announced today the scheduling of a Wednesday, April 17, 1985, full committee hearing to review an Administration report on prospective payment for Skilled Nursing Facilities under the Medicare program.

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) directed the Administration to develop and report on prospective payment proposals for skilled nursing facilities and submit them for review by both houses of the Congress. The Deficit Reduction Act of 1984 reiterated Congress' interest in the TEFRA report and required that it include description of the range of options for prospective payment.

Senator Packwood said testimony would be received from an invited representative of the Health Care Financing Administration.

The hearing is scheduled to begin at 9:30 a.m., Wednesday, April 17, 1985, in Room SD-215 of the Dirksen Senate Office Building.

OPENING STATEMENT
SENATOR BOB DOLE

SKILLED NURSING FACILITIES

IT IS A PLEASURE TO WELCOME THOSE WITNESSES APPEARING BEFORE US TODAY. I AM PARTICULARLY PLEASED THAT WE WILL HAVE THE OPPORTUNITY TO HEAR FROM THE ADMINISTRATION ON THEIR LONG OVERDUE SKILLED NURSING FACILITY REPORT. HOWEVER, I MUST SAY AT THE OUTSET HOW DISAPPOINTED I AM THAT WE DO NOT HAVE BEFORE US TODAY YOUR RECOMMENDATIONS FOR EITHER LEGISLATION OR ADMINISTRATIVE CHANGES THAT MIGHT RESULT IN INCREASED ACCESS TO THESE SERVICES BY MEDICARE BENEFICIARIES. I WILL BE ANXIOUS TO HEAR OF YOUR PROGRESS IN THIS REGARD.

MY INTEREST AND THAT OF MY COLLEAGUES IN THE SKILLED NURSING FACILITY BENEFIT HAS INCREASED OVER THE YEARS HAVING BEGUN IN THE LATE 1970'S. THIS INTEREST RESULTED IN LEGISLATIVE CHANGES WHICH WERE INCORPORATED INTO TEFRA, THE SOCIAL SECURITY AMENDMENTS OF 1983 AND FINALLY DEFRA. I FULLY EXPECT THIS ACTION TO CONTINUE UNTIL WE ARE SATISFIED THAT WE HAVE IN PLACE A REALISTIC PAYMENT SYSTEM THAT

ASSURES ACCESS TO THESE SERVICES BY THE ELDERLY. OF COURSE THE NEED TO RESOLVE THIS ISSUE HAS BECOME EVEN MORE PRESSING AS A RESULT OF THE IMPLEMENTATION OF THE DRG SYSTEM.

THE DRAFT REPORT PREPARED BY THE DEPARTMENT, WHICH IS THE SUBJECT OF OUR HEARING TODAY, CONTAINS A GREAT DEAL OF INTERESTING INFORMATION. FOR EXAMPLE, IT APPEARS TO CONFIRM OUR BELIEF THAT HOSPITAL BASED FACILITIES CARE FOR SICKER PATIENTS. HOWEVER, IT ALSO UNDERSCORES THE LACK OF INFORMATION AVAILABLE WHICH WOULD PERMIT US TO PUT INTO PLACE A PATIENT SPECIFIC OR EVEN INSTITUTION SPECIFIC PAYMENT SYSTEM. IT MAY BE THAT WE WILL HAVE TO USE SOME OTHER PROXY CASE MIX MEASURE, BUT LETS MAKE SOME MOVEMENT.

CONCLUSION

IN RECENT YEARS WE HAVE DONE VERY LITTLE TO REALLY ADDRESS THE UNDERLYING PROBLEMS WITH THE SKILLED NURSING FACILITY BENEFIT. THE SWING BED PROVISION AGREED TO A NUMBER OF YEARS AGO WAS AN ATTEMPT TO ADDRESS A RELATIVELY SMALL PART OF THE PROBLEM--THAT IS ACCESS TO SUBACUTE BEDS

BY INDIVIDUALS LIVING IN VERY RURAL COMMUNITIES. THUS THE SWINGING OF HOSPITAL BEDS WAS NEVER VIEWED AS A LONG TERM SOLUTION TO THE PROBLEM OF ACCESS TO THESE SERVICES.

WHAT WE NEED IS A CLEAR MOVEMENT AWAY FROM OUR CURRENT METHODS OF REIMBURSEMENT, TOWARDS A SYSTEM THAT ADEQUATELY COMPENSATES FACILITIES FOR CARING FOR MEDICARE PATIENTS WHILE STILL CREATING SOME INCENTIVES FOR EFFICIENCY.

WHILE RECOGNIZING THAT MEDICARE IS A VERY SMALL PART OF THE LONG TERM CARE BUSINESS, WE MUST MAKE AN EFFORT TO ASSURE THAT ACCESS TO SKILLED SERVICES IS AVAILABLE TO THOSE IN NEED. WE CANNOT SIMPLY WATCH THE CHANGE ON THE HOSPITAL SIDE TAKE PLACE WHICH ENCOURAGES THE EARLY DISCHARGE OF PATIENTS WITHOUT WORRYING ABOUT WHERE THESE PATIENTS TO FOR SUBACUTE CARE.

REMARKS OF
SENATOR DAVE DURENBERGER
MEDICARE SKILLED NURSING FACILITIES BENEFITS
APRIL 17, 1985

FOR YEARS I'VE ARGUED THAT THE ULTIMATE GOAL OF HEALTH SYSTEMS REFORM IS CAPITATION. FOR MEDICARE THIS MEANS THE FEDERAL GOVERNMENT WILL PAY A PREMIUM FOR MEDICARE BENEFICIARIES TO A COMPREHENSIVE HEALTH PLAN AND THE MEDICARE CONSUMER WILL CHOOSE AMONG THE COMPETING PLANS. BUT, THE PLAN OPTION FOR BENEFICIARIES WILL NOT BECOME A REALITY TOMORROW. IT IS ONLY STARTING NOW.

CAPITATION PROVIDES THE RIGHT INCENTIVES--INCENTIVES FOR PROVIDERS TO APPROPRIATELY SUBSTITUTE LOWER LEVELS OF CARE AT A LOWER COST AND INCENTIVES FOR THE ENHANCEMENT OF QUALITY. TREATMENT OF THE MEDICARE BENEFICIARY IF FOLLOWED THROUGH FOR AN ENTIRE SPELL OF ILLNESS, IN AND OUT OF THE HOSPITAL.

BUT CAPITATION IS TOMORROW'S REALITY. IN THE INTERIM, I'VE SUPPORTED THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITALS. DRGS HAVE INTRODUCED THE FINANCIAL INCENTIVES NEEDED FOR HOSPITALS TO BE COST-EFFECTIVE PROVIDERS OF CARE. I SEE THIS AS AN IMPORTANT REFORM, AN INTIAL STEP IN HELPING HOSPITALS BETTER MANAGE THEIR RESOURCES. REFORMING THE WAY MEDICARE PAYS FOR POST-HOSPITAL SERVICES IS THE NEXT LOGICAL STEP IN THIS LONG-TERM STRATEGY OF MEDICARE REFORM.

UNDER THE CURRENT SYSTEM, DECISIONS AS TO HOW MUCH WE PAY, FOR HOW LONG, AND FOR WHAT TYPES OF MEDICARE SERVICES ARE DECISIONS MADE BY PEOPLE LIKE SENATOR PACKWOOD AND MYSELF WHO ARE ~~NOT~~ CLEARLY NOT THE EXPERTS. UNDER A CAPITATED SYSTEM THE DESIGN AND PAYMENT FOR THE SUBACUTE SERVICES BECOMES THE PROBLEM OF THE HEALTH PLAN. AND THESE ARE THE PEOPLE WHO KNOW WHAT THEY'RE DOING AND ARE BASING THEIR PURCHASING DECISIONS ON THE BEST INTEREST OF THE BENEFICIARY AND THE PRICE IN THE MARKET PLACE.

IP But, as I have said we are not to capitation yet, so the Congress has to remain concerned about the specific benefits.

AFTER THE IMPLEMENTATION OF PROSPECTIVE PAYMENT FOR HOSPITALS, REFORM OF THE MEDICARE SKILLED NURSING BENEFIT ~~SEEMED LIKE THE NEXT LOGICAL STEP IN THE MOVEMENT TOWARD A CAPITATED SYSTEM~~ is a must. BUT FOR THREE YEARS, CONGRESS HAS ASKED THE ADMINISTRATION FOR RECOMMENDATIONS ON HOW TO ESTABLISH A PROSPECTIVE PAYMENT SYSTEM FOR SKILLED NURSING FACILITIES. THE DEFICIT REDUCTION ACT EVEN REQUIRED THE ADMINISTRATION TO INCLUDE IN THEIR RECOMMENDATIONS AN ANALYSIS OF MY PROPOSAL TO USE AN ADD-ON TO THE HOSPITAL DRG SYSTEM TO PAY FOR HOSPITAL BASED SKILLED NURSING CARE.

WHILE I AM PLEASED THAT THE ADMINISTRATION HAS FINALLY RELEASED THEIR FIRST SNF REPORT, I AM DISAPPOINTED THAT THAT IT LACKED WHAT WE'VE ALL BEEN WAITING FOR--RECOMMENDATIONS FOR REFORM.

THE VOLUME OF THE REPORT AND THE SCOPE OF ITS DETAIL, VERIFY THE COMPLEXITIES INVOLVED IN MEDICARE SNF REFORM. ALTHOUGH MEDICARE CURRENTLY PAYS FOR ONLY 2 PERCENT OF ALL NURSING HOME CARE AND SPENDS LESS THAN 1 PERCENT OF THE MEDICARE BUDGET ON SKILLED NURSING FACILITIES, REFORMING THE WAY WE PAY FOR SNF SERVICES WILL HAVE A SIGNIFICANT EFFECT ON THE WHOLE AREA OF AFTERCARE.

THE ISSUE OF POST-HOSPITAL CARE IS BECOMING INCREASINGLY IMPORTANT AS THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITALS IS ENCOURAGING HOSPITALS TO MOVE MEDICARE THEIR PATIENTS OUT OF THE HOSPITAL AS SOON AS IT IS MEDICALLY POSSIBLE. CONCERN ABOUT THE AVAILABILITY AND QUALITY OF POST-HOSPITAL TREATMENT IS JUSTIFIED.

THE PURPOSE OF THE HEARING TODAY, AS I SEE IT, IS TO FIND OUT (1.) WHAT THE PROBLEMS ARE WITH THE MEDICARE SNF BENEFIT, (2.) WHAT WE CAN DO IN THE IMMEDIATE ENVIRONMENT OF PPS TO RECTIFY THESE PROBLEMS AND (3.) WHAT WE NEED TO DO IN THE LONG-RUN TO CONTINUE THE MOVEMENT OF REFORM IN THE DIRECTION OF CAPTITATION.

IN THE NEAR TERM WE WILL NEED TO DESIGN A PAYMENT SYSTEM THAT HAS THE RIGHT INCENTIVES--TO PROVIDE HIGH QUALITY CARE WHILE ENCOURAGING THE COST-EFFECITVE MANAGMENT OF SERVICES. I URGE THE ADMINISTRATION TO WORK WITH US AS WE SORT THROUGH THESE ISSUE AND TO SUBMIT THEIR RECOMMENDATIONS TO CONGRESS AT THE EARLIEST POSSIBLE DATE. I LOOK FORWARD TO HEARING FORM THE WITNESSES TODAY AS WE SORT THROUGH THE NEXT STEP IN REFORM OF THE MEDICARE SYSTEM.

Opening Statement of Senator Grassley

MR. CHAIRMAN, THANK YOU FOR THE OPPORTUNITY TO HEAR FROM THESE DISTINGUISHED WITNESSES THIS MORNING ON REIMBURSEMENT REFORM FOR SKILLED NURSING FACILITIES. THE CONGRESS HAS BEEN INTERESTED SINCE THE ENACTMENT OF TEFRA IN 1982 IN THE STUDY OF THE FEASIBILITY OF PROSPECTIVE PAYMENT FOR MEDICARE SKILLED NURSING PROVIDERS, AN INTEREST WHICH WAS REITERATED IN CONGRESSIONAL DIRECTIVES BOTH IN THE SOCIAL SECURITY AMENDMENTS OF 1983 AND THE DEFICIT REDUCTION ACT OF 1984. IT IS MY UNDERSTANDING THAT ALTHOUGH THE HEALTH CARE FINANCING ADMINISTRATION HAS RESPONDED FINALLY WITH A REPORT DISCUSSING AN ANALYSIS OF SKILLED NURSING FACILITIES UNDER MEDICARE AND THE DIFFICULTIES WITH THE LACK OF DATA TO DEVELOP A MEDICARE SNF CASEMIX MEASURE, NO SPECIFIC PAYMENT REFORM PROPOSALS WILL BE OFFERED TODAY. MR. CHAIRMAN, I HOPE THAT THOSE RECOMMENDATIONS REQUESTED BY THE CONGRESS ARE FORTHCOMING IN THE NEAR FUTURE.

WE ACKNOWLEDGE THE SUCCESS OF THE PROSPECTIVE PAYMENT SYSTEM IN HOLDING DOWN MEDICARE EXPENDITURES FOR ACUTE MEDICAL CARE IN THE LAST TWO YEARS. YET AN IMPORTANT COST CONTAINMENT ASPECT OF THE PROSPECTIVE PAYMENT SYSTEM IS THAT IT GIVES HOSPITALS INCENTIVES TO KEEP PATIENTS IN AN ACUTE CARE SETTING ONLY AS LONG AS MEDICALLY NECESSARY. THEREFORE, IT IS NECESSARY AT THIS TIME TO EXAMINE THE EFFECT [redacted] ON POST-ACUTE BENEFITS UNDER MEDICARE, IF HOSPITALS DISCHARGE MORE PATIENTS TO MEDICARE SKILLED NURSING FACILTIES, REHABILITATION HOSPITALS AND SWING BEDS. ADDITIONALLY, BECAUSE REIMBURSEMENT RATES AND METHODS ARE DIFFERENT FOR THSE RELATED FORMS OF POST-ACUTE CARE, WE WILL HAVE TO EXAMINE REIMBURSEMENT PROPOSALS FOR SNFs IN THE LARGER CONTEXT OF ALTERNATIVE POST-ACUTE AND LONGTERM CARE.

WHILE I CERTAINLY FAVOR THE GOALS OF HEALTH CARE EFFICIENCY AND PRUDENT USE OF FINANCIAL RESOURCES, WE MUST ENSURE THAT ANY CHANGES WE MAKE IN MEDICARE REIMBURSEMENT DO NOT PUT AN UNDUE BURDEN ON OUR SKILLED NURSING FACILITIES. WE MUST ENSURE THAT SOME OF IOWA'S FEW SKILLED NURSING FACILITY BEDS ARE NOT EMPTIED DUE TO CONGRESSIONAL ENTHUSIASM TO REDUCE HEALTH CARE COSTS. ANY ALTERNATIVE REIMBURSEMENT SYSTEM SHOULD NOT ONLY ENCOURAGE EFFICIENCY, BUT INCREASE ACCESS TO SNFs FOR MEDICARE PATIENTS, PARTICULARLY HIGH COST, HEAVY CARE PATIENTS, AND REDUCE PAPERWORK REQUIREMENTS FOR FACILITIES.

MR. CHAIRMAN, I LOOK FORWARD TO HEARING THE TESTIMONY FROM THE ADMINISTRATION ON THIS IMPORTANT ISSUE, AS WELL AS RECOMMENDATIONS FROM THE NURSING HOME INDUSTRY AND HEALTH CARE CONSUMERS.

DRAFT DHHS REPORT TO CONGRESS
ON MEDICARE'S SKILLED NURSING FACILITY BENEFIT

I. BACKGROUND

A. Medicare's Skilled Nursing Facility Benefit

Medicare provides coverage for skilled nursing facility (SNF) services under its Part A Hospital Insurance Program. Coverage is provided for up to 100 days of care, per benefit period, 1/ and is available to persons who have had three consecutive days of hospital care and who have been admitted to a skilled nursing facility within 30 days after the hospital discharge. Such persons must also need skilled nursing or other skilled rehabilitation services on a daily basis for any of the conditions for which the individual was receiving inpatient hospital services. 2/ After the first 20 days of SNF care, beneficiaries must pay a daily coinsurance charge of one-eighth the inpatient hosptial deductible, currently equivalent to $50 a day.

Medicare law specifies that SNF services, also referred to as post-hospital extended care services, must be ordered by a physician and be provided by

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1/ A new benefit period begins when the beneficiary has not been an inpatient in a hospital or skilled nursing facility for 60 consecutive days.

2/ The Tax Equity and Fiscal Responsibility Act of 1982, P.L. 97-248, allows the Secretary to eliminate the three-day prior hospitalization requirement when he/she determines that such coverage will not lead to an increase in cost and will not alter the acute care nature of the benefit. To date the Secretary has not made any such determination.

or require the supervision of skilled nursing personnel. As a practical matter, the care can only be provided to a person on an inpatient basis in a skilled nursing facility, or at home if 24-hour nursing, or in a hospital.

SNF services under Medicare include:

(1) nursing care provided by or under the supervision of a registered professional nurse;

(2) bed and board in connection with the furnishing of nursing care;

(3) physical, occupational, or speech therapy furnished by the skilled nursing facility or by others under arrangements with the SNF;

(4) medical social services;

(5) drugs, biologicals, supplies, appliances, and equipment ordinarily furnished by the skilled nursing facility;

(6) medical services provided by an intern or resident of a hospital with which the skilled nursing facility has an agreement for a teaching program; and other diagnostic or therepeutic services provided by the hospital under this agreement; and

(7) such other services necessary to the health of the patients as are generally provided by skilled nursing facilities.

B. Program Statistics

In calendar year 1983, Medicare SNF expenditures amounted to $529 million and accounted for less than one percent of total Medicare expenditures and slightly less than two percent of total national nursing home expenditures.

Since 1975, both total expenditures and per diem payments for Medicare SNF care have increased at lower rates than most other Medicare covered services. Total Medicare expenditures for SNF care have increased from $278 million in 1975 to $529 million in 1983. The average annual rate of growth for total Medicare SNF expenditures between 1975 and 1983 was 8.4 percent. Per

diem payments increased at an average annual rate of 7.7 percent over the 1975-83 period. Over the same period, the SNF "market basket," a measure of the cost of food, utilities, nursing wages, etc., used to produce a day of nursing home care, grew at approximatley the same rate--8.3 percent annually. Since 1982, however, total expenditures have been increasing at rates higher than the market basket, indicating increases in utilization. In 1982 and 1983, both total covered days and rates of use increased.

Consistent with the acute-care nature of the benefit, the length of stay of Medicare SNF admissions is short relative to that of the general nursing home population. The mean number of Medicare covered days per admission was 29.6 days in 1980. A Health Care Financing Administration (HCFA) review of the length of stay distribution of Medicare covered days indicates that in 1980, 50 percent of admisions had less than 21 days of covered care. The percentage of admissions with 21 to 90 days of covered care declines steadily across ten-day intervals, until the final interval of 91-100 covered days when the percentage rises to 6.3 percent of total admissions. This last interval of 91-100 days accounted for 18.5 percent of all covered days.

C. Medicare SNF Reimbursement Policy

Skilled nursing facilities are reimbursed on the basis of reasonable costs actually incurred, subject to limits. Medicare's final payment to a SNF is determined retrospectively only after a SNF has itemized its costs for a full year on a Medicare cost report. In general terms, the method used to arrive at the Medicare payment to a SNF consists of determining (1) the SNF's total of the types of costs which Medicare allows, (2) what share of this total is attributable to Medicare patients, and (3) whether the resulting amount is "reasonable."

Medicare law (in section 1861(v)(1) and 1888 of the Social Security Act) authorizes the Secretary to set limits on allowable costs that will be reimbursed under Medicare. These limits are to be based on estimates of expenses for the efficient delivery of needed health services. Under this authority, HCFA has published limits on SNF per diem inpatient routine costs (for example, nursing, meals) since 1979. Capital-related and ancillary costs have been excluded from the cost limits. Approximately 35 percent of all participating SNFs have their reimbursements constrained by the limits.

Beginning with the initial implementation of limits on SNF inpatient routine costs in 1979, separate reimbursement limits were applied to hospital-based and freestanding SNFs, with the limits set higher for the hospital-based facilities. These limits were derived separately for hospital-based and freestanding facilities on the basis of the cost reports submitted by the two types of providers. Separate limits were implemented in regulations to take into account the higher incurred costs of hospital-based SNFs due to the allocation of overhead costs from hospitals required by Medicare reimbursement principles and higher intensity of care. Prior to amendments in 1982, these limits on routine costs were set at 112 percent of the respective mean of the routine costs for urban and rural hospital-based SNFs and 112 percent of the respective mean of the routine costs for urban and rural freestanding SNFs. In addition, adjustments were made for the differing levels of labor-related costs among the areas in which SNFs are located.

The separate limits were maintained until the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), P.L. 97-248, mandated a single set of limits for urban and rural SNFs based on the costs of freestanding facilities, subject to such adjustments as the Secretary deemed appropriate. This amendment had been recommended by the Administration on the assumption that hospital-based

and freestanding facilities provided the same service to the same patients. The Conference Report for for P.L. 97-248 specified that exceptions could be made on the basis of legitimate cost differences in hospital-based facilites resulting from such factors as a more complex casemix or the effects of Medicare reasonable cost determination rules. Implementing regulations established limits at 112 percent of the respective mean of the routine costs of urban and rural freestanding SNFs.

The regulations provided for add-on adjustments to account for certain higher costs of hospital-based SNFs. HCFA studies had indicated that some portion of the cost difference between hospital-based and the generally lower cost freestanding SNFs was attributable to overhead allocations required for hospital-based SNFs under Medicare reimbursement principles. This factor accounted for 8.8 percent of the higher routine operating costs of hospital-based SNFs in urban areas and 7.5 percent of the higher routine operating costs in rural areas. Adjustments in the reimbursement for hospital-based facilities were made according to this finding. HCFA did not routinely adjust for potential cost differences due to casemix because of the lack of reliable data on which to base such adjustments.

The Social Security Amendments of 1983, P.L. 98-21, subsequently postponed the effective date of TEFRA's single limit provision from October 1, 1982 to October 1, 1983, in order to give HCFA time to carry out a study to reevaluate its conclusion that the reimbursement limits for hosptial-based and freestanding SNFs should be essentially the same. Regulations were never issued implementing this delay.

The Deficit Reduction Act of 1984 (DEFRA), P.L. 98-369, effectively eliminated TEFRA's single reimbursement limit by providing that for cost reporting

periods beginning on or after October 1, 1982, and prior to July 1, 1984, the cost limits for routine services for urban and rural hospital-based SNFs shall be 112 percent of the mean of the respective routine costs for urban and rural hospital-based SNFs.

For periods on or after July 1, 1984, DEFRA specifies that separate limits should continue to be established for freestanding facilities in urban and rural areas at 112 percent of the mean operating cost of urban and rural freestanding facilities respectively. Limits for urban hospital-based facilities are to be equal to the urban freestanding facility limit plus 50 percent of the difference between the freestanding limit and 112 percent of mean operating costs for urban hospital-based facilities. A similar calculation, based on costs of rural facilities, is made for rural hospital-based facilities. Cost differences between hospital-based and freestanding facilities attributable to excess overhead allocations resulting from Medicare reimbursement principles are to be recognized as an add-on to the limit for hospital-based facilities. The Secretary can also make adjustments for differences in case-mix or for other circumstances beyond the control of the facility. Implementing regulations for DEFRA's amendments have not yet been issued.

II. REPORTS AND STUDIES ON SKILLED NURSING FACILITIES REQUIRED UNDER RECENTLY ENACTED LEGISLATION

Recently enacted legislation has required the Secretary of Health and Human Services to submit to Congress reports and studies on skilled nursing facility reimbursement.

Section 101 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), P.L. 97-248, required the Secretary to develop, in consultation with the Senate Finance Committee and the House Ways and Means Committee, legislative proposals for prospective reimbursement of skilled nursing facilities and other providers under Medicare. The Secretary was required to report on these proposals not later than December 31, 1982.

In section 605 of the Social Security Amendments of 1983, P.L. 98-21, Congress required the Secretary to complete a study and report on (1) the effect which the single reimbursement limit for SNFs (enacted in TEFRA) would have on hospital-based SNFs, given the differences (if any) in the patient populations served and (2) the impact on SNFs of hospital prospective payment systems, and recommendations concerning payment of SNFs.

The Deficit Reduction Act of 1984 (DEFRA), P.L. 98-369, reiterated Congress' mandate for the Secretary to submit the above reports and proposals on SNFs, which at the time of enactment had not been provided. Section 2319 of DEFRA required the Secretary to submit by December 1, 1984, the report required by P.L. 98-21. Section 2319 also required the Secretary to submit to Congress by August 1, 1984, a report on the legislative proposals required by TEFRA for prospective reimbursement of SNFs.

This section of DEFRA further required the Secretary to submit to Congress by December 1, 1984, a report on the range of options for prospective payment of SNFs under Medicare. This report is to take into account case-mix differences between facilities. In addition, the report is required to analyze the feasibility of permitting payment to be included to hospital-based SNFs within Medicare's DRG payment system for hospitals.

At this writing, none of these reports, proposals, or recommendations have been submitted to Congress. The Committee, however, has obtained a draft copy of a DHHS Report to Congress on SNF Care under Medicare. Its major findings have been summarized below.

III. MAJOR FINDINGS OF DRAFT DHHS REPORT ON MEDICARE'S SKILLED NURSING FACILITY BENEFIT

A draft copy of a DHHS Report to Congress on Medicare's Skilled Nursing Facility Benefit, obtained by the Committee and dated October 1984, indicates that the final report when released may (1) provide a descriptive analysis of Medicare's SNF benefit and participating facilities; (2) discuss reimbursement issues in the current system; (3) discuss the development of a Medicare SNF casemix measure; and (4) analyze the differences between hospital-based and free-standing SNFs. The report does not provide legislative proposals or recommendations concerning prospective payment for SNFs. The draft report indicates that these will be forwarded to Congress in a separate report. Major findings of the draft report include the following:

A. Statistics on Medicare SNFs

- A nursing home can be certified in whole or in part to participate in Medicare, Medicaid, or both programs. About 5,000 nursing homes are certified to provide Medicare services, about two-thirds of all SNFs. Approximately two-thirds of all Medicare certified SNFs are proprietary (for profit), with the rest about evenly split between government and non-profit facilities. Sixty-seven percent of the 5,000 Medicare certified facilities are urban and freestanding. (The 1980 National Master Facility Inventory Survey of Nursing and Related Homes, a survey conducted by the National Center for Health Statistics, identified 23,065 nursing homes in the country, but most of these do not provide the level of skilled care required of Medicare participants.)

- For participating SNFs, Medicare accounts for an average of 14 percent of patient days. However, less than 400 SNFs provide 40 percent of total Medicare days; these facilities are highly dependent on Medicare patients. The vast majority of certified SNFs provide very few Medicare days.

- The approximately 500 hospital-based facilities are evenly divided between urban and rural locations. Hospital-based facilities tend to provide proportionately more care to Medicare beneficiaries than freestanding SNFs, accounting for 20 percent of total days while supplying only 10 percent of certified beds.

- The availability of Medicare certified SNF beds in all types of facilities varies across States. New York and California account for almost 30 percent of all participating facilities, and six States (California, New York, Pennsylvania, Ohio, Michigan, and Florida) account for about half of total Medicare patient days, while the Medicare population in these six States amounts to 37 percent of the national Medicare population. In FY 1981, Medicare SNF beds per 1000 elderly varied from a low of 1 in Arkansas and Oklahoma to a high of 51 in North Dakota; the national mean was 18. The use rate of the Medicare covered SNF benefit also varied across States from a low of one day of Medicare covered SNF care per 1000 elderly in Wyoming to a high of 635 in Kentucky, the national mean was 310.

- The average total cost per day for Medicare SNF services was $80 in FY 1983, of which 72 percent was for routine operating costs, 22 percent for ancilliary costs, and 6 percent for capital costs. Nonprofit and urban homes are more expensive than proprietary and rural facilities. Hospital-based facilities are twice as expensive as freestanding facilities, $95 and $48 per day, respectively. However, hospital-based and freestanding SNFs in rural areas are more similar in costs than they are in urban localities.

B. Reimbursement Issues in the Current System

- The current retrospective, reasonable cost reimbursement system contains no incentives for facilities to admit Medicare or heavy care patients. Moreover, SNFs with costs above the reimbursement limits set by statute have strong incentives to reduce costs by admitting patients who require less care. (Thirty-five percent of Medicare SNFs are already being reimbursed at these limits.) In addition, it is often believed that, because of certain characteristics of the current reimbursement system, facilities decline to participate in Medicare, creating inadequate access and costly hospital back-up of patients awaiting nursing home placements. Three frequently noted deficiencies of the current system are: (1) the lack of financial incentives to curb costs and to increase efficiency; (2) excessive federal reporting requirements; and (3) financial uncertainty created by retrospective payment adjustments.

- A prospective payment system has been advocated as a means to increase SNF participation in the Medicare program if it would lead to simplified billing and reflect the higher costs of heavy care patients. Increased SNF participation potentially could increase the use of Medicare SNF services and decrease the number of hospital patients awaiting SNF placements. This would allow the patient to move through the system and be cared for at the medically necessary level. A prospective payment system with incentives to take Medicare patients could promote access for Medicare beneficiaries. In addition, research on prospective payment systems for Medicaid financed nursing home services tends to support the claim that prospective payment systems are more cost containing than retrospective payment systems.

- There are strong indications that local or regional factors greatly influence access to and use of Medicare SNF services. For example, States with Medicaid reimbursement systems providing strong incentives for nursing homes to become certified as intermediate care facilities (ICFs) tend to have nursing home industries that are predominantly ICF oriented. (Intermediate care is a lower level of care than skilled care and is not covered by the Medicare program.) Since Medicare constitutes such a small share of the overall market, it has little leverage to affect the availability of SNF level nursing home care.

- Other local and regional factors that affect Medicare SNF participation and the use of Medicare SNF services are variations in local medical practice patterns, the availability of home health services as an alternative to SNF care, and differences in the interpretation and application of coverage rules by fiscal intermediaries in light of these local and regional factors.

- With respect to the problem of the backlog of hospital patients awaiting nursing home placement, existing evidence suggests that many are awaiting Medicaid, not Medicare, placements. However, hospital prospective payment may exert a greater influence toward increasing the use of Medicare SNF services because it gives hospitals a strong financial incentive to discharge patients as soon as is medically appropriate. Thus, hospital prospective payment may increase demand for Medicare SNF care. It would, therefore, be desirable to have a payment system that encourages facilities to admit Medicare patients so they do not get backlogged in the hospital.

- It is important to note that there are constraints on the ability of the health care system to respond to increased demand for Medicare SNF services. Demand for skilled nursing facility beds already exceeds supply in most areas of the country, but most States regulate growth in bed supply via the "certificate of need" (CON) process and have

refused to grant many CON approvals for new nursing home construction or expansion in recent years as a means of controlling growth in Medicaid expenditures. Although exisiting facilities could choose to admit more Medicare patients, high demand for beds from Medicaid and private pay patients may freeze out Medicare patients where Medicare remains a comparatively small portion of the total market for nursing home care.

- We can expect the same increased efficiencies from SNF operations as has been experienced by changing the hospital reimbursement system based on historical costs to one based on prospective rates. Although the current system for paying SNFs does not inherently reward provider efficiency, the need is not as great as it was for hospital payments because of the relatively small amounts involved and because the expenditure growth rate for SNF services has been much lower than that for hospital care. From FY 1975-83, the annual rate of growth for Medicare SNF expenditures was 8.4 percent. This growth rate is essentially the same as the growth rate in the nursing home "market basket," a measure of the price of the inputs (e.g., food, nurses, etc.) necessary to produce a day of nursing home care. Since 1982, however, total expenditures have been increasing at rates higher than the market basket, indicating increases in utilization. In 1982 and 1983, both total covered days and rates of use increased.

- Skilled nursing facilities with more than a minimal Medicare caseload are required to complete the detailed hospital cost report. Given the relatively small Medicare caseload in most facilities, SNFs find this reporting requirement burdensome. Some prospective payment systems would reduce the paperwork requirements. In addition, prospective payment could eliminate the need for retrospective payment adjustments which take place under the current system.

C. Casemix Analysis

- Casemix measurement is a generic term referring to many approaches for determining differences in resources required by different classes of patients. Different resource requirements to meet different patient needs translate into differences in payment rates according to patient need. Without a casemix measure, providers have incentives to accept only patients requiring lower levels of care. Adjustment of payment for casemix could enhance access to SNF care for more severely ill patients because providers would be paid higher rates to care for sicker patients. If prospective rates are set without regard to casemix, providers could profit by admitting only patients with the lowest resource needs.

- Research specifically on the casemix of Medicare SNF patients is very limited, primarily because overall they make up such a small part of the nursing home population. The existing research on casemix and resource use in nursing homes has focused on the general nursing home population. Thus, these results may not be directly applicable to Medicare SNF patients because they are based on the long-term care needs of the general nursing home population rather than the short-term skilled or rehabilitative care Medicare SNF patients receive. This literature indicates that limitations in activities of daily living such as bathing, dressing, and feeding are most important in predicting resource composition and related costs. Diagnosis, the only patient-specific casemix information routinely collected on Medicare SNF patient conditions, is less important. Analysis of information on diagnoses of Medicare patients shows that there is a great deal of variation in the costs and lengths of stay among Medicare SNF patients with the same diagnosis. This indicates that diagnosis alone is not a good casemix measure for distinguishing among patients according to their resource needs.

- In the absence of sufficient data to derive a direct patient-specific casemix measure for Medicare SNF patients, an evaluation of existing facility data which might provide a proxy casemix measure based on facility characteristics was undertaken. It was found that Medicare days as a percent of total patient days is directly related to cost and may be used as a proxy casemix measure. Percent of Medicare days measures the extent to which facilities provide care to short-term skilled and rehabilitative patients rather than to long-term care patients. Analysis of freestanding facilities indicates that in 1980 a one percentage point increase in the proportion of Medicare days in a facility increased the per diem rate by 16 cents. For hospital-based facilities, a one percent increase in the proportion of Medicare days increased per diem costs by 56 cents. In addition, other analyses prepared specifically for this report indicate that Medicare patients have, on average, more frequent and severe medically-oriented problems. Thus, while not as powerful a casemix measure as DRGs, percent Medicare days might be used as a limited proxy casemix measure until sufficient data are collected and analyzed to develop a direct patient specific casemix measure. In developing such a casemix measure, various aspects of Medicare SNF cases, including diagnosis, disabilities, and specialized services, will need to be considered.

D. Differences in Costs Between Hospital-Based and Freestanding SNFs

- Differences in patient casemix appear to be one reason why hospital-based SNFs are more costly on average than freestanding SNFs. Other possible explanations for the cost difference include differences in quality of care and efficiency of operation. In addition, for Medicare reimbursement purposes, certain overhead or indirect expenses, such as administrative salaries, must be allocated between a hospital's acute care unit and subproviders such as the skilled nursing unit. Approximately 8 percent of total routine cost differences between hospital-based and freestanding SNFs has been determined to be due to overhead allocation in hospital-based facilities.

- A difference in casemix between hospital-based and freestanding SNFs is indicated by Medicare utilization and staffing data as well as the results of most outside studies. The Medicare data indicated that hospital-based SNFs had on average higher proportions of Medicare patient days to total days and higher admissions per bed. Both of these results suggest higher utilization by short-term rehabilitation patients who are likely to be more costly to care for than traditional long-term care patients.

- On average, hospital-based facilities had 19 percent more nursing hours than freestanding facilities. Hospital-based SNFs also provide more rehabilitation services than freestanding facilities. While these results suggest that hospital-based facilities are staffed to serve a more severe casemix, these data are insufficient to precisely isolate casemix effects from inefficiency and quality of care differences.

- Studies on casemix in hospital-based and freestanding facilities were reviewed for this report. Shaughnessy et al. (1983) studied case mix in high Medicare utilization SNFs and found hospital-based patients to be characterized by more sever medical problems (e.g., recovery from surgery, shortness of breath, intravenous catheters). Patients in freestanding SNFs tended to have more mental problems, terminal illness, and urinary tract infections. An analysis of casemix using data from the Medicare and Medicaid Automated Certification System (Sulvetta and Holahan, 1984) found that higher proportions of patients in hospital-based than freestanding SNFs had disability problems and needed specialized services. Three studies of low Medicare utilization facilities (Cameron and Knauf, 1983; Sulvetta and Holahan, 1984; and Shaughnessy et al., 1982) found differences in the casemix of hospital-based and freestanding SNFs, with most

of the evidence pointing toward greater severity of hospital-based patients. Mor and Sherwood (1983) found virtually no differences in Medicare diagnoses and disabilities between hospital-based and freestanding facilities in Oregon, and some differences in Massachusetts. In both States, hospital-based patients tend to be more rehabilitation oriented.

- Results from two studies carried out for this report suggest that casemix accounts for some of the cost differences between hospital-based and freestanding SNFs. Shaughnessy (1984) estimated that casemix differences between hospital-based and freestanding SNFs may explain up to 50 percent of their cost differences, while Sulvetta and Holahan (1984) estimated that 43 percent of the cost differences were due to casemix and staffing.

E. Major Conclusions

- DHHS analysis of available information indicates that important issues need to be considered before specific options for reimbursement reform of the Medicare SNF benefit can be addressed. A key issue is that no reliable and valid patient specific casemix measure currently exists for Medicare SNF patients and that further research is required.

- A second major issue is the effect of hospital prospective payment on SNFs and other postacute benefits under Medicare. Since hospital payment under Medicare is on a per case basis, hospitals will have incentives to keep patients in an acute care setting only as long as is medically necessary. Thus, some observers predict that hospitals will discharge more patients to Medicare SNFs and other postacute units, such as rehabilitation hospitals and "swing beds." Because the Medicare SNF patient appears in many cases to resemble a beneficiary cared for in a rehabilitation setting and/or a hospital swing bed, the examination of reimbursement alternatives for SNFs should also take into account these related forms of postacute care.

- The quality of care for Medicare beneficiaries needs to be ensured under any SNF proepective payment system. The Department is engaged in reseacch and operational initiatives that are intended to improve our ability to examine patient outcomes to assure quality of care.

IV. ISSUES

1. Legislative Proposals and Recommendations for SNF Prospective Payment

As noted above, Congress, since 1982, has requested reports and legislative proposals and recommendations for prospective payment of SNF care under Medicare. A copy of a draft DHHS report on SNF care under Medicare indicates that specific SNF payment reform proposals will be forwarded to Congress in still another report at some later point in time. The draft report indicates that additional research is required specifically on the relationships between casemix and resource consumption of Medicare SNF patients before specific proposals can be made.

2. Research on Prospective Payment for SNF Care under Medicare

The draft report indicates that DHHS is sponsoring additional research on the relationships between casemix and resource consumption of Medicare SNF patients. This research includes analyses of the relationship between hospital DRGs and SNF costs, identification of SNF resource utilization groups (RUGs) under which patients are classified according to resources they use in the SNF, and development of Medicare patient-specific casemix indices. Questions arise as to whether information from these studies will be adequate to construct a national prospective payment system for SNF care. As noted

above, Medicare SNF patients make up a small part of the nursing home population and the vast majority of certified SNFs provide very few Medicare days. These and other factors complicate the development of a uniform prospective payment system. In addition, HCFA indicates that it has only one major study underway which is looking at Medicare SNF patients in five States. Other questions arise as to when research will yield results to allow implementation of a prospective payment system. Current research is focused on developing a classification system for SNF care which will define the relationship between casemix and resource consumption of Medicare SNF patients. Additional research will then be required by which to translate this classification system into a pricing system.

3. Impact of Medicare's Hospital Prospective Payment System on Medicare SNF Services

Medicare's hospital prospective payment system may increase the use of Medicare SNF services because it gives hospitals a strong financial incentive to discharge patients as soon as is medically appropriate. It has been noted that a prospective payment system for SNFs could increase SNF participation and promote access for Medicare beneficiaries in greater need of SNF care. It should also be noted that patient characteristics using Medicare SNF services may change with full implementation of hospital prospective payment. This has implications for any research on a casemix measure for SNF care. Questions arise as to how DHHS research on SNF prospective payment takes into account the effects of hospital prospective payment on SNF patients and their use of SNF resources.

4. Proxy Casemix Measures

If current information is inadequate for developing a prospective payment system based on casemix, are there useful steps which can be taken to provide some of the benefits of a reimbursement system based on casemix. The draft report indicates that the proportion of Medicare patient days to total facility days might be used as a limited proxy casemix measure until sifficient data are collected and analyzed to develop a direct patient specific casemix measure. HCFA currently collects the information necessary to construct this variable for all participating SNFs. Questions arise as to why HCFA has not proposed payment reform based on this proxy measure and how reform would actually be accomplished with such an adjustment.

The CHAIRMAN. The committee will please come to order. We are starting this morning on what could be a series of hearings involving Medicare, Medicaid, and skilled nursing facilities, and other related issues. It is very clear that skilled nursing facilities provide an important component of services provided by Medicare to America's senior citizens. Given the major changes that we have made in Medicare, the possibility that we may make more, and the changes that we are making in the health sector, it is important that this committee maintain its vigilence over all aspects of the Medicare program. Specifically, this hearing will allow us to review the report on skilled nursing facilities, just completed by HCFA, to hear nursing home industry experts, and consumer comments on this report, and raise and explore other problems that may not be covered in the report. Our first witness today is Dr. Carolyne Davis, the Administrator of the Health Care Financing Administration, and you are accompanied by Thomas Ault and Robert Streimer.

Are you ready?

Dr. DAVIS. Yes, sir.

The CHAIRMAN. Go right ahead. I very much again appreciate the witnesses having gotten their testimony in. They will be in the record in full, and I had a chance last night and this morning to read all of your testimony, and so we would appreciate it if you could abbreviate it. Excuse me, Senator Durenberger, do you have an opening statement?

Senator DURENBERGER. Yes, I do, and I will be brief. I have argued for a long time that the ultimate goal of health systems reform is capitation, and for Medicare that means the Federal Government will pay a premium for Medicare beneficiaries to a comprehensive health plan, and the Medicare consumer will choose among competing plans, but all of that is not going to happen tomorrow or the day after tomorrow, even though it has started. A capitated system provides the right incentives—that is the incentives for providers to appropriately substitute lower level care at a lower cost—and incentives for the enhancement of quality treatment of the Medicare beneficiary, if followed through for an entire

spell of illness in and out of the hospital. But capitation is tomorrow's reality. In the interim, I have been supporting a prospective payment system for hospitals. It seems to be working, certainly with the help of HCFA and others. And it strikes me that some form of a prospective payment system with the incentives that we see operating on the hospital side would be important as far as the access of Medicare beneficiaries to skilled nursing. Mr. Chairman, I would ask that the balance of my statement be made part of the record.

The CHAIRMAN. Without objection, it will be in the record in its entirety. Senator Dole.

Senator DOLE. Thank you, Mr. Chairman. I would ask that my statement be made a part of the record. I would just indicate that I am pleased that we are going to finally have an opportunity to hear from the Administration on what I believe to be a long-overdue skilled nursing facility report, and I would add that I am quite disappointed that we do not have before us today administration recommendations, either legislation or administrative changes that might result in increased access to these services by Medicare beneficiaries. I think many of us have been interested in this since way back in the late 1970's, and we have made some changes in TEFRA in 1982 and also TEFRA and later what we refer to as DEFRA. And I think it is fair to say we are going to continue these efforts until we have been satisfied that we have in place a realistic payment system that assures access to these services by the elderly. Of course, the need to resolve this issue has become even more pressing as a result of the implementation of the DRG system. The draft report prepared by the department, which is the subject we are hearing today, contains a great deal of interesting information. It appears to confirm our belief that hospital based facilities care for sicker patients. However, it also underscores the lack of information available which would permit us to put into place a patient-specific or even an institution-specific payment system. It may be that we will have to use some other proxy case-mix measure to let us make some movement. So, I am very pleased that we are having the hearings. I hope it will result in some administration movement.

The CHAIRMAN. What may happen—and you are absolutely right—is, if we have no administration recommendations, we may just blunder on ahead ourselves and do the best we can.

Senator DOLE. Better than blundering backward. [Laughter.]

The CHAIRMAN. Dr. Davis, go right ahead.

STATEMENT OF CAROLYNE K. DAVIS, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Dr. DAVIS. Thank you, Mr. Chairman. Let me just briefly summarize my statement. First of all, it is important to remember the differences between the Medicare skilled nursing facility benefit and the Medicaid. The Medicare benefit, of course, is a post-hospital extended care benefit for the lower-cost skilled nursing facility. It has a maximum coverage of up to 100 days. It is, of course, of an acute care nature, and the benefit is relatively small as a part of

the Medicare total. It is less than 1 percent of our total Medicare expenditures.

The CHAIRMAN. It is about $550 million, as I recall.

Dr. DAVIS. That is right, sir. And it is actually less than 2 percent of the total that this Nation spends on its nursing home care. The average beneficiary stays in the skilled nursing facility only about 30 days. About two-thirds of all of these nursing homes are certified to provide Medicare extended care services. The vast majority of them, however, provide just a very few Medicare days. That contrasts very definitely with the Medicaid benefit which provides a long-term benefit for patients who are unable to continue to live independently. The average length of stay for the skilled nursing facility patient under Medicaid is 456 days, and the total cost of that part of the program in Medicaid is $8.4 billion. So, in terms of the contrast, I think it is quite definitely a different benefit program. If you look at the differences between hospital-based and freestanding facilities, as has already been alluded to, there is currently a significant difference. At the moment, Medicare reimburses the skilled nursing facilities on a retrospective cost basis, subject to the limits that are applied to the routine costs that are set prospectively at 112 percent of the average costs for both rural and urban facilities. I would like to point out that Congress has changed that policy on the limits three times since 1982.

In 1982 under the TEFRA, a single cost limit was mandated for all skilled nursing facilities based upon the experience of the lower cost freestanding facilities. In 1983 Congress delayed the single limits and required a study. And then in 1984, under the Deficit Reduction Act, there was a mandate to modify the single limit to allow the hospital based facilities an add-on of 50 percent of the difference between the free-standing limits and the 112 percent of the mean costs of the hospital-based facilities. Looking at the issue of prospective payment for skilled nursing facilities, we recognize that the current retrospective payment is indeed unsatisfactory. It simply doesn't encourage the nursing homes to admit Medicare beneficiaries who have a heavy-care need. It does lack the financial incentives which we have in place in the hospital system to have the homes want to control their costs. It requires excessive reporting, and it creates some degree of financial uncertainty in terms of an adjustment retrospectively. And we think that it also contributes potentially to the possibility of some backlog of patients in the hospital waiting for an available SNF bed, although I think that is more inclined to be a Medicaid problem and not a Medicare problem. Many of the States' Medicaid programs have moved since 1980 to develop a prospective payment system. A number of their programs—I think about 38 of the States—now have a prospective payment system. Each one has some unique features, and we have been studying those, but it is important to remember that the Medicare patients are significantly different from the Medicaid patients because of the Medicare benefit's acute short-term nature; so that the knowledge that we collect on the Medicaid long-term population can't necessarily be generalized to the Medicare population. Therefore, when we consider a prospective Medicare SNF Program, we have to think about those kinds of variations that we are learning about across the many States, and then think about the compli-

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cations that might arise in applying the same system to the Medicare Program. Medicare costs for the SNF's haven't risen at the same rate as the other Medicare costs have either, and the ability of the Medicare prospective payment system to influence the skilled nursing facility overall cost increase would be limited. We think that there needs to be additional consideration given to the impact that the hospitals' prospective payment system would have on the needs in the skilled nursing facility, and we are looking at that at this point in time. Likewise, we are also trying now to devise studies that will follow the impact of the prospective payment system on the quality of care, both in terms of prospective payment systems in the Medicaid programs, as well as the impact of the hospitals' prospective payment system. In terms of our research, it has shown very clearly and strongly that resource use is related to patient care needs. In other words, we would need to have a differential in the system that would be related to casemix because the relative resources that are used to take care of different patients seem to explain somewhere up to 50 percent of the cost differential. The evidence would suggest then that a casemix adjustment is an important design element in any Medicare prospective payment system in order to address the needs of heavy-care patients. And it is the heavy-care patient need that we are most concerned about. So, we have undertaken a number of studies to develop a casemix classification system. We have three major studies. Yale has developed a classification system that essentially looks at the activities of daily living, and we refer to those as Resource Utilization Groups, or RUG's. We believe that those groups would account for about 38 percent of the variation in resource use among patients, and they seem to reveal significant variation even among patients with the same diagnosis. We have a demonstration in New York State which is looking at refining the classification of the RUG's, according to five different clinical categories. And we believe that might increase the explanatory power up to 52 percent. Because we also have been concerned about the fact that the Medicare beneficiaries do have different needs, we funded a study with the Rensselaer Polytechnic Institute to develop a Medicare-specific case-mix measurement.

We expect the data results from that will be due in this fall. Meanwhile, we have developed and have identified two possible proxy measures that would explain the higher costs. It seems that the Medicare days as a percentage of the total patient days and the higher number of admissions per bed explain the higher cost. However, we are not certain that those measures are sufficient to use as a prospective payment methodology. There may be other factors, such as diagnosis, disabilities, and other kinds of specialized services that need to be factored in. Once we have a case-mix measure for the Medicare SNF, we would then have the problem of developing a payment rate for each patient grouping. Our current SNF records don't include the necessary information so we need to develop a method to collect that data, and we will be doing that over this next year's time. We are also assessing the feasibility of developing a payment system that combines the hospital's prospective payment rate and a payment for the skilled nursing facility care. That system, which would be based upon the episode of care, has

the potential to eliminate the incentives for a hospital to have too many or too early transfers, and it could encourage the use of more swingbeds in the hospital. The development of that particular system has to address a number of complex issues, such as the wide variation in the skilled nursing facility patient diagnostic categories, and must look at the number of DRG's that would need to be adjusted; whether we would adjust all of them or only certain ones that have a heavy use of the skilled nursing facility. But we are developing the data bases that will link the episodes and the hospital and the post-hospital care. In our analysis, we will consider how to resolve those issues to construct a budget-neutral payment methodology, for testing in a demonstration. We would expect the demonstration of that bundled concept to begin next year. So, although we have made a great deal of progress in developing the basic elements on which we are building this system, we still have many important questions that need to be answered before we can develop a national payment methodology. We have given a high priority in our research program to continuing to develop the methodologies in this new prospective payment. I think it is important to remember that when we developed and tested the prospective payment system for hospitals, we did that on the basis of 10 years of research, and we have now had approximately 2 years of research in the skilled nursing facility prospective payment area. Finally, it is important to recognize that we need to avoid any premature solution that could cost more money or that in any way could create problems in terms of access that we would not want to see happen. I think at that point I would say that is the complete summary, and I would be pleased to answer any questions.

The CHAIRMAN. Thank you, Dr. Davis.

[Dr. Davis' prepared written statement follows:]

STATEMENT OF CAROLYNE K. DAVIS, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

I AM PLEASED TO BE HERE TODAY TO DISCUSS THE MEDICARE SKILLED NURSING FACILITY (SNF) BENEFIT AND OUR PROGRESS IN DESIGNING A PROSPECTIVE PAYMENT SYSTEM FOR SNF CARE. WITH ME TODAY IS MR. ROBERT STREIMER, DEPUTY DIRECTOR OF THE BUREAU OF ELIGIBILITY, REIMBURSEMENT AND COVERAGE, AND MR. THOMAS AULT, DIRECTOR, OFFICE OF POLICY ANALYSIS.

OVER THE LAST SEVERAL YEARS CONGRESS HAS EXPRESSED INTEREST IN THE DEVELOPMENT OF PROPOSALS PROVIDING FOR PROSPECTIVE PAYMENT FOR MEDICARE PROVIDERS, INCLUDING SNFS. IN RESPONSE TO THESE CONGRESSIONAL MANDATES, WE ARE SUBMITTING A REPORT THAT SETS THE FOUNDATION FOR THE DEVELOPMENT OF SUCH SNF PROPOSALS. THE REPORT PROVIDES A DETAILED ANALYSIS OF THE MEDICARE SNF BENEFIT AND THE STRUCTURE OF THE INDUSTRY; DISCUSSES THE DEVELOPMENT OF A MEDICARE SNF CASE-MIX MEASURE; ANALYZES THE DIFFERENCES BETWEEN HOSPITAL-BASED AND FREESTANDING SNFS; AND ADDRESSES OTHER REIMBURSEMENT ISSUES. SPECIFIC SNF PAYMENT REFORM PROPOSALS WILL BE ADDRESSED IN A SEPARATE REPORT. TODAY, I WILL BRIEFLY SUMMARIZE THE REPORT WE ARE SUBMITTING.

THE MEDICARE SKILLED NURSING BENEFIT AND INDUSTRY

WHEN THE MEDICARE PROGRAM WAS ENACTED, CONGRESS DECIDED TO PROVIDE A POST-HOSPITAL "EXTENDED CARE" BENEFIT TO COVER SHORT-TERM, POST-ACUTE CARE NECESSARY TO A PATIENT'S RECOVERY. THIS "EXTENDED CARE" BENEFIT PERMITS A PATIENT WHO HAS BEEN HOSPITALIZED TO CONVALESCE IN A LOWER COST, QUALIFIED SKILLED NURSING FACILITY FOR UP TO 100 DAYS. THE SNF BENEFIT INCLUDES STRINGENT REQUIREMENTS TO ASSURE ITS

ACUTE CARE NATURE. FOR EXAMPLE, COVERAGE IS LIMITED TO PATIENTS WHO HAVE BEEN IN THE HOSPITAL AT LEAST THREE DAYS AND NEED DAILY SKILLED NURSING CARE OR RELATED REHABILITATION SERVICES.

BECAUSE OF ITS LIMITED ACUTE CARE NATURE, THE MEDICARE SNF BENEFIT IS RELATIVELY SMALL, BOTH AS A PERCENTAGE OF MEDICARE EXPENDITURES AND NURSING HOME REVENUES. IN FISCAL YEAR 1984, MEDICARE SPENT $545 MILLION FOR SNF BENEFITS -- LESS THAN ONE PERCENT OF TOTAL MEDICARE EXPENDITURES AND LESS THAN TWO PERCENT OF TOTAL NATIONAL NURSING HOME INCOME. MEDICARE ALSO REQUIRES THAT BENEFICIARIES SHARE IN THE COST OF SNF BENEFITS AFTER 20 DAYS IN THE NURSING FACILITY. THE AMOUNT OF THE SNF COINSURANCE IS BASED ON A PERCENTAGE OF THE HOSPITAL DEDUCTIBLE AND IS $50 PER DAY IN 1985.

THE LIMITED SCOPE OF THE MEDICARE SNF BENEFIT ALSO MEANS THAT THE AVERAGE MEDICARE BENEFICIARY STAYS IN A SKILLED NURSING FACILITY ONLY A SHORT TIME -- ABOUT 30 DAYS IN 1983.

IN 1984, ABOUT TWO-THIRDS OF ALL NURSING HOMES OR ABOUT 5,800 SKILLED NURSING FACILITIES WERE CERTIFIED TO PROVIDE MEDICARE EXTENDED CARE SERVICES. MEDICARE PATIENTS RECEIVED 8.7 MILLION DAYS OF COVERED SNF CARE IN THESE FACILITIES.

HOWEVER, THESE DAYS WERE NOT EQUALLY DISTRIBUTED AMONG THE PARTICIPATING SNFS. FEWER THAN 400 SNFS PROVIDE 40 PERCENT OF TOTAL MEDICARE DAYS AND THE VAST MAJORITY OF CERTIFIED SNFS PROVIDE FEW MEDICARE DAYS.

THE AVAILABILITY OF CERTIFIED SNF BEDS VARIES ACROSS STATES, PARTLY BECAUSE STATES CAN CONTROL NURSING HOME EXPANSION AND CONSTRUCTION THROUGH CERTIFICATE OF NEED REQUIREMENTS. IN 1981, MEDICARE SNF BEDS PER 1000 ELDERLY VARIED FROM A LOW OF 1 IN ARKANSAS AND OKLAHOMA TO A HIGH OF 51 IN NORTH DAKOTA; THE NATIONAL MEAN WAS 18. THE UTILIZATION RATE ALSO VARIES ACROSS STATES FROM A LOW OF 1 DAY OF COVERED CARE PER 1000 ELDERLY IN WYOMING TO A HIGH OF 612 IN KENTUCKY; THE NATIONAL MEAN WAS 316.

THE MEDICARE SKILLED NURSING BENEFIT CONTRASTS SHARPLY WITH NURSING HOME BENEFITS UNDER MEDICAID. MEDICAID PROVIDES A LONG TERM BENEFIT IN EITHER A SKILLED OR INTERMEDIATE CARE FACILITY. MEDICAID DOES NOT LIMIT SNF CARE TO POST-HOSPITALIZATION CASES, BUT RATHER TO PATIENTS WHO ARE UNABLE TO CONTINUE TO LIVE INDEPENDENTLY. IN 1980, THE AVERAGE NON-MEDICARE SNF PATIENT SPENT 450 DAYS IN A NURSING HOME. AS MIGHT BE EXPECTED, NURSING HOME COSTS ARE A MUCH HIGHER PROPORTION OF MEDICAID PROGRAM COSTS, REPRESENTING 42 PERCENT, OR $8.4 BILLION IN 1984. .

Hospital-Based and Freestanding Facilities

Medicare currently reimburses SNFs on a retrospective cost basis subject to limits applied to routine costs, such as nursing care and meals. Capital and ancillary costs, such as physical therapy or lab procedures, are not included in the cost limits. Limits are set prospectively at 112 percent of the average costs of rural and urban facilities.

In 1982, the Tax Equity and Fiscal Responsibility Act (TEFRA, P.L. 97-248) mandated single cost limits for all SNFs based on the experience of lower-cost freestanding facilities. The Secretary was authorized to adjust these single limits to account for case-mix or cost differences in hospital-based facilities. When the regulations on the single TEFRA limits were published, we did not include a case-mix factor because we had neither the data to conclude that there was a case-mix difference nor knowledge about how to construct such an adjustment. In 1983, Congress mandated that the single TEFRA limits be delayed and that a study be conducted of the new single limit requirement. Our study shows that case-mix accounts for some of the cost differences between hospital-based and freestanding SNFs.

In 1984, the Deficit Reduction Act (P.L. 98-369) mandated a modified single limit based on the costs of freestanding facilities with an "add-on" for hospital-based facilities. The formula increases the limit for these facilities by 50 percent of the difference between the freestanding limit and 112 percent of the mean cost of hospital-based facilities.

Prospective Payment for SNFs

We agree with the Congress and the nursing home industry, that the current retrospective payment system for SNFs is unsatisfactory. This system does not encourage nursing homes to admit Medicare beneficiaries who have heavy care needs; lacks financial incentives for nursing homes to control costs; requires excessive reporting; and creates financial uncertainty by adjusting payment retrospectively. Critics believe that this payment system is largely responsible for the low participation of nursing homes in the Medicare program and the back-log of patients in the hospital waiting for an available SNF bed.

Prospective payment systems are designed to provide incentives for providers to control costs by establishing a rate of payment in advance for a defined set of benefits. Through efficient management of patient care, providers ma

COVER THEIR COSTS AND RETAIN ANY SAVINGS THEY INCUR. IMPORTANT CRITERIA FOR SUCCESSFUL PROSPECTIVE PAYMENT SYSTEMS ARE THAT THE PAYMENT RATE BE PERCEIVED AS EQUITABLE BY THE PROVIDERS AND THAT QUALITY OF CARE BE ASSURED FOR THE PATIENTS.

MOST STATE MEDICAID PROGRAMS HAVE DEVELOPED PROSPECTIVE PAYMENT SYSTEMS FOR THEIR NURSING HOME PROGRAMS. THESE SYSTEMS WERE ADOPTED TO ACHIEVE DIFFERENT GOALS INCLUDING COST CONTAINMENT, MORE ACCURATE PAYMENT RELATED TO A FACILITY'S PATIENT MIX, IMPROVED QUALITY, OR DECREASED BACKLOG OF PATIENTS. DESIGN OF A PROSPECTIVE PAYMENT SYSTEM FOR MEDICARE MUST CONSIDER A NUMBER OF FACTORS THAT ARE UNIQUE TO THE MEDICARE NURSING HOME BENEFIT. THESE INCLUDE:

- MEDICARE PATIENTS ARE SIGNIFICANTLY DIFFERENT FROM OTHER SNF PATIENTS. THE ACUTE, SHORT-TERM NATURE OF THE MEDICARE SNF BENEFIT MEANS THAT MEDICARE PATIENTS ARE IN NURSING HOMES FOR SPECIFIC, RECUPERATIVE SERVICES, AND NOT FOR THE TYPICAL MAINTENANCE REGIMEN PRESCRIBED FOR OTHER NURSING HOME PATIENTS. EVEN THOUGH MEDICARE PATIENTS HAVE MORE SEVERE MEDICAL PROBLEMS, THEY APPEAR TO BE MORE INDEPENDENT IN THE ACTIVITIES OF DAILY LIVING, SUCH AS BATHING, OR FEEDING, THAN THE GENERAL NURSING HOME RESIDENT.

- Prospective payment systems require a detailed knowledge of patient characteristics and related resource use. The knowledge collected on the general long term care population cannot be generalized to the Medicare population because of the nature of the benefits and population served. Thus, it has been necessary to develop expanded data bases to permit analysis of specific Medicare issues, such as patient characteristics, diagnosis, and service use.

- The Medicare SNF program varies greatly from State to State and across SNFs, in terms of availability and utilization. Local factors, such as variations in medical practice and the structure of the nursing home industry in a particular State influence access and use of services. These variations need to be better understood.

- Although direct Medicare costs for SNFs have increased in recent years (an average of about 8 percent each year for the past 5 years), these costs have not risen at the same rate as other Medicare costs or nursing home costs in general. Since Medicare beneficiaries

REPRESENT SUCH A SMALL SEGMENT OF THE NURSING HOME INDUSTRY. THE ABILITY OF A MEDICARE PROSPECTIVE PAYMENT SYSTEM TO INFLUENCE OVERALL COSTS OF SNFs IS LIMITED.

- THE IMPACT OF THE HOSPITAL PROSPECTIVE PAYMENT SYSTEM ON THE MEDICARE SNF BENEFIT NEEDS TO BE CONSIDERED. DATA ARE NOT YET AVAILABLE TO DETERMINE FULLY THE NATURE OR EXTENT OF THIS IMPACT, BUT PRELIMINARY FINDINGS ARE THAT THE PERCENTAGE OF MEDICARE PATIENTS DISCHARGED TO SNF CARE HAS REMAINED RELATIVELY CONSTANT. WE MUST EXAMINE WHETHER THE INCENTIVES IN THE NEW HOSPITAL PAYMENT SYSTEM MAY RESULT IN INCREASED DEMAND FOR MEDICARE NURSING HOME BEDS AS PATIENTS ARE DISCHARGED AS EARLY AS POSSIBLE, AND WHETHER MEDICARE PATIENTS MAY REQUIRE MORE INTENSIVE SERVICES. WE ALSO NEED TO ASSURE THAT SAVINGS FROM OUR HOSPITAL PROSPECTIVE PAYMENT SYSTEM ARE NOT CONSUMED BY ADDITIONAL SNF SPENDING.

- WE MUST ALSO CONSIDER HOW A PROSPECTIVE PAYMENT SYSTEM MAY AFFECT QUALITY OF CARE. MEANINGFUL MONITORING SYSTEMS NEED TO BE DEVELOPED TO ASSURE THAT THE SNF LEVEL OF CARE IS APPROPRIATE AND THAT NECESSARY SERVICES ARE DELIVERED.

Case-Mix and Nursing Home Costs

Our research shows that resource use in a nursing home is strongly related to patient care needs. Studies of the higher costs of hospital-based facilities as compared to lower-cost freestanding facilities reveal that the relative resources used by different patients may explain up to 50 percent of the cost differential. For example, hospital-based facilities have more licensed nurses, more nursing hours, and a greater orientation toward more expensive rehabilitation services. Patients in hospital-based facilities also tend to have more severe medical problems, higher rates of disability and greater need for specialized services.

This evidence suggests that case-mix adjustments are important in the design of a Medicare prospective payment system. Without provisions to pay higher amounts for patients who require more resources, SNFs will not have the incentive to participate in Medicare, or will accept only Medicare patients who require less intensive care.

WE HAVE THEREFORE UNDERTAKEN A NUMBER OF STUDIES TO DEVELOP A CASE-MIX CLASSIFICATION SYSTEM THAT WILL MEASURE THE RESOURCE USE ATTRIBUTABLE TO DIFFERENT MEDICARE PATIENT CHARACTERISTICS. ONCE THESE MEASURES ARE DEVELOPED, PROFILES OF RELATIVE NEEDS CAN BE DEVELOPED AS THE BASIS OF A PAYMENT METHODOLOGY.

FOUR MAJOR STUDIES HAVE BEEN UNDERTAKEN TO DEVELOP MEDICARE CASE-MIX MEASURES. THE FIRST THREE STUDIES FOCUSED ON DEVELOPMENT OF PATIENT-SPECIFIC MEASURES, WHILE THE FOURTH STUDY ASSESSED THE CHARACTERISTICS OF SPECIFIC FACILITIES AS A SUBSTITUTE MEASURE.

- AN EARLY STUDY CONDUCTED BY YALE DISCOVERED THAT A SMALL NUMBER OF PATIENT CHARACTERISTICS, ESSENTIALLY THE ACTIVITIES OF DAILY LIVING SUCH AS BATHING, DRESSING, OR FEEDING, ARE THE BEST PREDICTORS OF PATIENT CARE NEEDS. NINE GROUPS OF PATIENTS WITH SIMILAR NEEDS WERE CREATED. THESE GROUPS WERE CALLED RESOURCE UTILIZATION GROUPS, OR RUGS. WHEN APPLIED TO 63 SKILLED NURSING FACILITIES IN CONNECTICUT, THESE GROUPS ACCOUNTED FOR 38 PERCENT OF THE VARIATION IN RESOURCE USE AMONG PATIENTS. THIS PILOT TEST REVEALED SIGNIFICANT VARIATION IN COSTS AND LENGTH OF STAY

AMONG PATIENTS WITH THE SAME DIAGNOSIS, SUGGESTING THAT DIAGNOSIS MAY NOT BE A USEFUL PREDICTOR OF RESOURCE USE BY LONG TERM CARE PATIENTS. THE YALE STUDY FINDINGS WERE INSUFFICIENT TO DEVELOP A CASE-MIX MEASURE FOR A NATIONAL MEDICARE PROGRAM BECAUSE THE STUDY FOCUSED ON FACILITIES IN ONE STATE, AND THE SAMPLE INCLUDED ONLY A SMALL NUMBER OF MEDICARE PATIENTS.

- A DEMONSTRATION IS UNDERWAY IN NEW YORK TO REFINE AND TEST THE RUGS SYSTEM FOR USE IN A MEDICAID CASE-MIX REIMBURSEMENT SYSTEM. THE CLASSIFICATION SYSTEM, RUGS II, IS NOW COMPLETE. THIS SYSTEM GROUPS PATIENTS ACCORDING TO 5 CLINICAL CATEGORIES, -- SPECIAL CARE, CLINICALLY COMPLEX, REHABILITATIVE, SEVERE BEHAVIORAL, REDUCED PHYSICAL FUNCTIONING. EACH GROUP IS FURTHER SPLIT ACCORDING TO THE PATIENTS ACTIVITIES OF DAILY LIVING CHARACTERISTICS. THE RESULT IS 16 RESOURCE UTILIZATION GROUPS. THE RUGS II CLASSIFICATION SYSTEM WAS APPLIED TO A SAMPLE OF MEDICARE PATIENTS AND DETERMINED THAT THE EXPANDED GROUPINGS AND THE ADDITION OF THE CLINICAL VARIABLE INCREASED THE EXPLANATION OF

VARIATION ACROSS PATIENTS TO 52 PERCENT OF RESOURCE USE. AS IN THE YALE STUDY, ANALYSIS OF PRIMARY MEDICARE DIAGNOSES, E.G., CANCER, STROKE, OR HIP FRACTURE, SHOWED A SIGNIFICANT AMOUNT OF COST VARIATION WITHIN DIAGNOSTIC CATEGORIES. A PAYMENT METHODOLOGY BASED ON WEIGHTED RUGs II GROUPINGS IS CURRENTLY BEING CONSTRUCTED FOR MEDICAID PATIENTS AND WILL BE IMPLEMENTED IN THE DEMONSTRATION IN 1986.

- BOTH THE YALE AND NEW YORK STUDIES RELY PRIMARILY ON MEDICAID PATIENT CHARACTERISTICS FOR THEIR CASE-MIX CLASSIFICATION SYSTEM. HOWEVER, EVIDENCE THAT MOST MEDICARE BENEFICIARIES HAVE DIFFERENT NEEDS THAN THE AVERAGE LONG TERM CARE PATIENT SUGGESTS THAT DIFFERENT CASE-MIX MEASURES AND RESOURCE USE MAY APPLY TO THE MEDICARE POPULATION. WE THEREFORE HAVE FUNDED A STUDY WITH RENSSELAER POLYTECHNIC INSTITUTE TO DEVELOP A MEDICARE SPECIFIC CASE-MIX MEASUREMENT SYSTEM. WORK IS NOW UNDERWAY TO DEVELOP THE MEDICARE RESOURCE UTILIZATION GROUPS. THIS SYSTEM WILL BUILD ON THE YALE AND NEW YORK MODELS, BUT WILL ALSO ASSESS THE ROLE DIFFERENT DIAGNOSES AND TYPES OF SERVICE TREATMENT HAVE

ON RESOURCE UTILIZATION. DATA ARE NOW BEING COLLECTED IN 5 STATES. THIS STUDY IS EXPECTED TO PRODUCE CASE-MIX WEIGHTS FOR EACH RUG THAT CAN BE USED IN A MEDICARE PROSPECTIVE PAYMENT SYSTEM. RESULTS ARE EXPECTED THIS FALL.

- BECAUSE WE REALIZED THAT THE DEVELOPMENT OF A CASE-MIX MEASURE BASED ON SPECIFIC MEDICARE PATIENT FACTORS WOULD INVOLVE A COMPLEX AND SOMEWHAT LENGTHY PROCESS. WE UNDERTOOK STUDIES TO DETERMINE IF WE COULD DEVELOP A PROXY MEASURE USING FACILITY SPECIFIC DATA THAT COULD BE USED IN THE INTERIM. WE FOUND THAT MEDICARE DAYS AS A PERCENTAGE OF TOTAL PATIENT DAYS IS DIRECTLY RELATED TO COST. OUR DATA SHOWED THAT IN 1980 A ONE PERCENT INCREASE IN THE PROPORTION OF MEDICARE DAYS IN A FACILITY INCREASED THE PER DIEM RATE BY 18 CENTS FOR FREESTANDING FACILITIES AND 58 CENTS FOR HOSPITAL-BASED FACILITIES. WE ALSO FOUND THAT FACILITIES THAT HAVE A HIGHER NUMBER OF ADMISSIONS PER BED ARE ALSO MORE LIKELY TO PROVIDE SHORT TERM, REHABILITATIVE CARE. WHILE MEDICARE DAYS AND ADMISSIONS PER BED MAY BE USEFUL AS PROXY MEASURES FOR CASE-MIX ADJUSTMENTS IN A

PROSPECTIVE PAYMENT SYSTEM, THEY ARE NOT SUFFICIENT. THE METHODOLOGY WILL NEED TO CONSIDER OTHER FACTORS SUCH AS DIAGNOSIS, DISABILITIES, AND SPECIALIZED SERVICES AS WELL.

THE SUCCESSFUL DEVELOPMENT OF CASE-MIX MEASURES FOR MEDICARE SNF PATIENTS IS ONLY THE FIRST STEP IN DEVELOPING A PROSPECTIVE PAYMENT SYSTEM. THE MORE COMPLICATED PROBLEM IS HOW TO DEVELOP A PAYMENT RATE FOR EACH PATIENT GROUPING. IN THE CASE OF HOSPITALS, WE WERE ABLE TO LINK OUR CLASSIFICATION SYSTEM (THE DIAGNOSIS RELATED GROUPS) TO ROUTINELY REPORTED COST DATA TO DERIVE A RELATIVE COST FOR EACH CATEGORY. OUR SNF RECORDS DO NOT INCLUDE INFORMATION ON PATIENT FUNCTIONAL OR CLINICAL CHARACTERISTICS OR PATIENT RESOURCE USE, SUCH AS NURSING TIME, THAT COULD BE MATCHED TO OUR COST INFORMATION. THUS, WE WOULD HAVE TO DEVELOP A METHOD TO COLLECT THESE DATA BEFORE WE COULD DEVELOP A PAYMENT RATE. THE RELATIVELY SHORT PATIENT STAY AND THE SMALL NUMBER OF MEDICARE PATIENTS IN EACH FACILITY PRESENT DIFFICULT PROBLEMS IN OBTAINING THE NECESSARY DATA, AND IN DEVELOPING AN ADMINISTRATIVE PROCEDURE THAT IS LESS CUMBERSOME THAN THE CURRENT SYSTEM.

Bundling Hospital and SNF Care

Since the Medicare SNF benefit is essentially an extension of the hospital acute care benefit, the possibility of developing a payment system that combines the hospital prospective payment and a payment for SNF care appears attractive. Under such an approach, the hospital would contract and pay for nursing home services on the patient's behalf, and would assume responsibility for managing the entire patient episode of care. Such a system would give the hospital a financial stake in the efficient use of all acute care services. It has the potential to eliminate incentives for a hospital to have "too many" or "too early" transfers to SNFs, and could encourage the use of "swing beds" in the hospital if nursing home beds were unavailable, or if facilities were more costly.

However, the development of such a system must address a number of complex issues.

The most difficult problem we are encountering is how to adjust the hospital payment method which is based on diagnosis related groupings (DRGs). The early case-mix studies found wide variation in the use of post-hospital

SERVICES WITHIN THE SAME DIAGNOSIS. WE ARE LOOKING AT ADJUSTMENTS THAT MIGHT PREDICT THE USE OF SNF OR HOME HEALTH SERVICES, SUCH AS FAMILY STATUS OR AGE. A SECOND ISSUE IS WHETHER WE SHOULD ADJUST PAYMENT RATES FOR ALL HOSPITAL PATIENTS OR ONLY THE 5 PERCENT WHO USE EXTENDED CARE SERVICES. THERE ARE ALSO A NUMBER OF COMPLEX OPERATIONAL ISSUES TO BE ASSESSED. WE ARE NOW DEVELOPING DATA BASES THAT WILL LINK EPISODES OF HOSPITAL AND POST-HOSPITAL CARE. OUR ANALYSES WILL CONSIDER HOW TO RESOLVE THESE ISSUES TO CONSTRUCT A BUDGET NEUTRAL PAYMENT METHODOLOGY FOR TESTING IN DEMONSTRATIONS.

CONCLUSION

OUR RESEARCH AND DEMONSTRATION EFFORTS HAVE HELPED US TO UNDERSTAND THE UNIQUE FEATURES OF THE MEDICARE SNF BENEFIT AND THE MAJOR ISSUES THAT NEED TO BE ADDRESSED IN DEVELOPING A PROSPECTIVE PAYMENT SYSTEM FOR SNFS. ALTHOUGH WE HAVE MADE MUCH PROGRESS IN DEVELOPING THE BASIC ELEMENTS ON WHICH WE CAN BUILD SUCH A SYSTEM, WE STILL HAVE MANY IMPORTANT QUESTIONS THAT MUST BE ANSWERED BEFORE WE CAN DEVELOP A NATIONAL PAYMENT METHODOLOGY. OUR GOAL IS A SYSTEM THAT

PROVIDES EQUITABLE RATES, INCREASES ACCESS TO QUALITY CARE FOR MEDICARE BENEFICIARIES AND IS EASY TO ADMINISTER. WE HAVE GIVEN A HIGH PRIORITY IN OUR RESEARCH PROGRAM TO THE CONTINUED DEVELOPMENT OF METHODOLOGIES FOR SNF PROSPECTIVE PAYMENT.

I'M SURE YOU WILL AGREE THAT THE COMPLEXITY OF THE PROBLEM IS SUCH THAT WE MUST AVOID PREMATURE SOLUTIONS THAT MAY RESULT IN MORE COST, BURDEN OR ACCESS PROBLEMS THAN UNDER OUR PRESENT COST REIMBURSEMENT SYSTEM. WE BELIEVE THAT WE ARE ON THE RIGHT TRACK TO FINDING SUITABLE ALTERNATIVES THAT ARE COMPATIBLE WITH OUR MUTUAL GOALS FOR REFORM.

I WILL BE PLEASED TO ANSWER ANY QUESTIONS YOU MAY HAVE.

STUDY OF THE SKILLED NURSING FACILITY BENEFIT UNDER MEDICARE

EXECUTIVE SUMMARY

This Report responds to a congressional mandate concerning the Medicare skilled nursing facility benefit. First, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) required the Department of Health and Human Services to develop proposals providing for prospective payment for Medicare providers, including skilled nursing facilities (SNFs). Second, the Social Security Amendments of 1983 included a requirement that the Department study the effect of implementing the 1982 TEFRA provision requiring single payment limits for both Medicare freestanding and hospital-based SNF services based on the cost experience of freestanding facilities. Third, the Deficit Reduction Act of 1984 reiterated Congress' interest in the studies specified by TEFRA and the 1983 Social Security Amendments and provided, further, that the Department should report on the range of options for prospective payment of skilled nursing facilities under Medicare. This report provides a detailed analysis of the Medicare SNF benefit, analyzes the structure of this industry, discusses the development of a Medicare SNF casemix measure, and analyzes the differences between hospital-based and freestanding SNFs. This report also addresses the reimbursement issues involved in the Medicare SNF benefit; however, as required by the 1984 Deficit Reduction Act, specific SNF payment reform proposals will be forwarded to the Congress in a separate report.

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In preparing this Report, the Department conducted a thorough analysis of internal administrative data on Medicare SNF patients and participating facilities, reviewed the existing literature on casemix and costs in nursing homes, and commissioned four outside studies to assess the casemix differences between hospital-based and freestanding SNFs. The results of this research are presented in this Report. They represent the most complete picture of the Medicare SNF industry available to date.

The Report is divided into an introduction and five chapters:

Introduction

Chapter I: Background and Context

Chapter II: Statistics on the Facilities in the Medicare Program

Chapter III: The Current Reimbursement System

Chapter IV: Analysis of Casemix Measurement in Skilled Nursing Facilities

Chapter V: Hospital-Based and Freestanding Facilities

The Department will continue to respond to the Congressional mandate to develop a proposal for prospective payment for the SNF benefit under Medicare and expects to forward such a proposal in the near future. This additional time will provide an opportunity to utilize new information that becomes available as well as to ensure that the recommended SNF prospective payment system works in concert with the hospital prospective payment system.

Background and Context

The Medicare skilled nursing benefit covers short-term (no more than 100 days), post-acute care for persons needing skilled nursing or rehabilitative services in an inpatient setting. The Medicare SNF benefit as mandated by statute sets specific and relatively stringent requirements regarding the level of skilled care necessary for Medicare coverage of SNF services. Hence, Medicare covered SNF care differs from the long term care covered by the Medicaid nursing home benefit. In 1980 the average Medicare coverage of a SNF stay was 30 days, much less than the average stay of 456 days for all nursing home patients.

The Medicare SNF benefit is relatively small both as a percentage of Medicare expenditures and as a proportion of total national nursing home revenues. The $529 million spent for Medicare SNF benefits in calendar year 1983 constituted slightly less than one percent of total Medicare expenditures and slightly less than two percent of all nursing home expenditures. On the other hand, in 1983 about 31 percent of Medicaid expenditures were for nursing home care (skilled nursing and intermediate care facilities), and Medicaid accounted for nearly 50 percent of all nursing home expenditures.

Currently, Medicare services in skilled nursing facilities are reimbursed on a retrospective reasonable cost basis, subject to limits applied to routine costs (e.g., nursing, meals). Ancillary costs such as physical therapy and drugs and capital are not included in the cost limits. The limits are set at 112 percent of the average costs of urban and rural facilities. Prior to October 1, 1982, separate limits were in effect for hospital-based and freestanding facilities. TEFRA eliminated these dual cost limits, mandating single limits based on the lower costs of the freestanding

facilities subject to such adjustments as the Secretary deems appropriate. The Deficit Reduction Act extended the pre-TEFRA dual limits to July 1, 1984. After July 1, 1984, reimbursement limits for urban and rural hospital-based SNFs respectively, would be set at the corresponding limits for freestanding SNFs plus 50 percent of the amount by which 112 percent of the hospital-based SNF costs exceeded the limit for freestanding SNFs.

As with all benefits under Medicaid, States are free to establish their own payment systems. As a result, there is considerable variation in SNF reimbursement methods under Medicaid. In constrast to Medicare's retrospective reimbursement system, 37 States employ various forms of prospective payment. Only 10 States use a retrospective system similar to Medicare's. Three States use a method that combines various approaches.

Statistics on Medicare SNFs

A nursing home can be certified in whole or in part to participate in Medicare, Medicaid, or both programs. About 5,000 nursing homes are certified to provide Medicare services, about two-thirds of all SNFs. Approximately two-thirds of all Medicare certified SNFs are proprietary (for profit), with the rest about evenly split between government and non-profit facilities. Sixty-seven percent of the 5,000 Medicare certified facilities are urban and freestanding. For participating SNFs, Medicare accounts for an average of 14 percent of patient days. However, less than 400 SNFs provide 40 percent of total Medicare days; these facilities are highly dependent on Medicare patients. The vast majority of certified SNFs provide very few Medicare days.

The approximately 500 hospital-based facilities are evenly divided between urban and rural locations. Hospital-based facilities tend to provide proportionately more care to Medicare beneficiaries than freestanding SNFs, accounting for 20 percent of total days while supplying only 10 percent of certified beds.

The availability of Medicare certified SNF beds in all types of facilities varies across States. In FY 1981, Medicare SNF beds per 1000 elderly varied from a low of 1 in Arkansas and Oklahoma to a high of 51 in North Dakota; the national mean was 18. The use rate of the Medicare SNF benefit also varied across States from a low of one day of Medicare covered SNF care per 1000 elderly in Wyoming to a high of 635 in Kentucky; the national mean was 310.

The average total cost per day for Medicare SNF services was $80 in FY 1983, of which 72 percent was for routine operating costs, 22 percent for ancillary costs, and 6 percent for capital costs. Nonprofit and urban homes are more expensive than proprietary and rural facilities. Hospital-based facilities are twice as expensive as freestanding facilities, $95 and $48 per day, respectively. However, hospital-based and freestanding SNFs in rural areas are more similar in costs than they are in urban localities.

In a multivariate regression analysis, facility characterisitics (e.g., ownership hospital-based/freestanding, facility size) explained about half of the facility variation in routine operating costs. Two proxy measures of casemix, proportion of Medicare days to total patient days and total admissions per bed, are associated with higher costs.

Reimbursement Issues in the Current System

The current retrospective, reasonable cost reimbursement system contains no incentives for facilities to admit Medicare or heavy care patients. Moreover, SNFs with costs above the reimbursement limits set by statute have strong incentives to reduce costs by admitting patients who require less care. In addition, it is often believed that, because of certain characteristics of the current reimbursement system, facilities decline to participate in Medicare, creating inadequate access and costly hospital back-up of patients awaiting nursing home placements. Three frequently noted deficiencies of the current system are: 1) the lack of financial incentives to curb costs and to increase efficiency; 2) excessive federal reporting requirements; and 3) financial uncertainty created by retrospective payment adjustments.

A prospective payment system has been advocated as a means to increase SNF participation in the Medicare program. Increased SNF participation potentially could increase the use of Medicare SNF services and decrease the number of hospital patients awaiting SNF placements. This would allow the patient to move through the system and be cared for at the medically necessary level. A prospective payment system with incentives to take Medicare patients could promote access for Medicare beneficiaries.

There are strong indications, however, that local or regional factors greatly influence access to and use of Medicare SNF services. For example, States with Medicaid reimbursement systems providing strong incentives for nursing homes to become certified as intermediate care facilities (ICFs) tend to have nursing home industries that are predominantly ICF oriented. (Intermediate care is a lower level

of care than skilled care which is not covered by the Medicare program.) Since Medicare constitutes such a small share of the overall market, it has little leverage to affect the availability of SNF level nursing home care. Other local and regional factors that affect Medicare SNF participation and the use of Medicare SNF services are variations in local medical practice patterns, the availability of home health services as an alternative to SNF care, and differences in the interpretation and application of coverage rules by fiscal intermediaries in light of these local and regional factors.

With respect to the problem of the backlog of hospital patients awaiting nursing home placement, existing evidence suggests that many are awaiting Medicaid, not Medicare, placements. However, hospital prospective payment may exert a greater influence toward increasing the use of Medicare SNF services because it gives hospitals a strong financial incentive to discharge patients as soon as is medically appropriate. Thus, hospital prospective payment may increase demand for Medicare SNF care. It would, therefore, be desirable to have a payment system that encourages facilities to admit Medicare patients so they do not get backlogged in the hospital.

Because state certificate of need (CON) requirements limit the capacity of SNFs to respond to increasing demand by increasing bed supply, it is also important to take into account how alternative reimbursement systems and incentives may affect the use of other types of postacute care such as rehabilitation hospitals and swing beds. Under Medicare, rehabilitation hospitals and rehabilitation units of general hospitals are providers that must be engaged primarily in rehabilitation as defined, in part, by 75 percent of their patients being treated for conditions that typically require inpatient rehabilitation. The swing bed option under Medicare

allows small hospitals (under 50 beds), operating in rural areas where there is a scarcity of long-term care beds, to use their beds for either acute or long-term care services. The expected increase in demand for postacute care implies that specific options for prospective payment need to provide incentives to allow SNFs to manage heavier Medicare caseloads and also to promote the most efficient use of SNFs in relation to other postacute benefits under Medicare. Although rehabilitation hospitals and swing beds are currently subject to different reimbursement rules under Medicare than SNFs, they may, in some cases, serve similar types of patients. For example, average lengths of stay in some of these units, like that of SNFs (29 days), are relatively short. Both rehabilitation units and rehabilitation hospitals average 22 days per stay, while swing bed stays average 13 days. On the other hand, while SNFs are currently reimbursed at cost up to limits based on the average costs of participating facilities, rehabilitation hospitals and units are reimbursed at cost up to limits based on each facility's base-year costs adjusted for inflation. Equally dissimilar are the reimbursement rules for swing beds used for long-term care; when its swing beds are used for long-term care patients, a hospital is reimbursed for routine costs at a per diem rate equal to its state's average Medicaid SNF rate.

We can expect the same increased efficiencies from SNF operations as has been experienced by changing the hospital reimbursement system based on historical costs to one based on prospective rates. Although the current system for paying SNFs does not inherently reward provider efficiency, the need is not as great as it was for hospital payments because the expenditure growth rate for SNF services has been much lower than that for hospital care. From FY 1975-83, the annual rate of growth for Medicare SNF expenditures was 8.4 percent. This growth rate is essentially the same as the growth rate in the nursing home "market basket", a

measure of the price of the inputs (e.g., food, nurses, etc.) necessary to produce a day of nursing home care. In recent years, total SNF expenditures have grown at rates higher than the marketbasket. From 1981 to 1982 the increase in total expenditures was 10 percent higher than changes in marketbasket, while the corresponding comparison was 128 percent from 1982 to 1983. These increases were due principally to increases in utilization.

Skilled nursing facilities with more than a minimal Medicare caseload are required to complete the detailed hospital cost report. Given the relatively small Medicare caseload in most facilities, SNFs find this reporting requirement burdensome. Some prospective payment systems would reduce the paperwork requirement. With respect to retroactive payment adjustments, prospective payment could alleviate reimbursement rate changes.

Casemix Analysis

The development of a casemix measure is important in the design of a prospective payment system for Medicare SNF services. Casemix measurement is a generic term referring to many approaches for determining differences in resources required by different patients. Different resource requirements to meet different patient needs translate into differences in payment rates according to patient need. The central casemix measure under Medicare hospital prospective payment is a patient specific one called diagnosis-related groups (DRGs). Under hospital prospective payment, DRGs which require more resources (e.g., longer lengths of stay, more laboratory tests) are paid at higher amounts. Without provisions to pay higher amounts for patients who require more resources, hospitals would have incentives to accept only patients requiring lower levels of care, making it very

difficult for severely ill patients to receive hospital care. This same dynamic applies to SNF services today where, without a casemix measure, providers have incentives to treat lighter care patients.

Research specifically on the casemix of Medicare SNF patients is very limited, primarily because overall they make up such a small part of the nursing home population. The existing research on casemix and resource use in nursing homes has focused on the general nursing home population. Thus, these results may not be directly applicable to Medicare SNF patients because they are based on the long term care needs of the general nursing home population rather than the short-term skilled or rehabilitative care Medicare SNF patients receive. This literature indicates that limitations in activities of daily living such as bathing, dressing, and feeding are most important in predicting resource consumption and related costs. Diagnosis, the only patient-specific casemix information routinely collected on Medicare SNF patient conditions, is less important. Analysis of information on diagnoses of Medicare patients shows that there is a great deal of variation in the costs and lengths of stay among Medicare SNF patients with the same diagnosis. This indicates that diagnosis alone is not a comprehensive casemix measure for distinguishing among patients according to their resource needs.

In the absence of sufficient data to derive a direct patient-specific casemix measure for Medicare SNF patients, an evaluation of existing facility data which might provide a proxy casemix measure based on facility characteristics was undertaken. It was found that Medicare days as a percent of total patient days is directly related to cost and may be used as a proxy casemix measure. Percent Medicare days measures the extent to which facilities provide care to short-term skilled and rehabilitative patients rather than to long term care patients. Analysis

of freestanding facilities indicates that in 1980 a one percentage point increase in the proportion of Medicare days in a facility increased the per diem rate by 16 cents. For hospital-based facilities a one percent increase in proportion Medicare increased per diem costs by 56 cents. In addition, other analyses prepared specifically for this Report (Shaughnessy et al., 1983; Sulvetta and Holahan, 1984) indicate that Medicare patients have, on average, more frequent and severe medically-oriented problems. Thus, while not as powerful a casemix measure as DRGs, percent Medicare days might be used as a limited proxy casemix measure until sufficient data are collected and analyzed to develop a direct patient specific casemix measure. In developing such a casemix measure, various aspects of Medicare SNF cases, including diagnosis, disabilities, and specialized services, will need to be considered.

Hospital-Based and Freestanding SNFs

That higher costs of hospital-based SNFs relative to freestanding SNFs may be due to differences in casemix between the two types of providers has been a major issue in reimbursement policies for Medicare SNFs. The absence of empirical evidence to resolve the issue resulted in different policies for reimbursing hospital-based SNFs at different times and a mandate from Congress to investigate the extent to which the higher costs of hospital-based SNFs are attributable to heavier care patients.

Sufficient information is currently not available to definitively quantify the proportion of the existing cost differences that can be attributed to the various factors such as unmeasured casemix, quality of care, and inefficiency. Percent Medicare days, a proxy measure for casemix, is associated with higher costs and,

on average, hospital-based SNFs have higher percent Medicare days than freestanding SNFs. Medicare program data on staffing patterns indicate that hospital-based SNFs have more nursing hours, more licensed nurses, and a greater orientation toward rehabilitation that freestanding SNFs, suggesting a different casemix between the two types of facilities.

Shaughnessy et al. (1983) studied casemix in high Medicare utilization SNFs and found hospital-based patients to be characterized by more severe medical problems (e.g., recovery from surgery, shortness of breath, intravenous catheters). Patients in freestanding SNFs tended to have more mental status problems, terminal illness, and urinary tract infections. An analysis of casemix using data from the Medicare and Medicaid Automated Certification System (Sulvetta and Holahan, 1984) found that higher proportions of patients in hospital-based than freestanding SNFs had disability problems and needed specialized services. Three studies of low Medicare utilization facilities (Cameron and Knauf, 1983; Sulvetta and Holahan, 1984; and Shaughnessy et al., 1982) found differences in the casemix of hospital-based and freestanding SNFs, with most of the evidence pointing toward greater severity of hospital-based patients. Mor and Sherwood (1983) found virtually no differences in Medicare diagnoses and disabilities between hospital-based and freestanding facilities in Oregon, and some differences in Massachusetts. In both States, hospital-based patients tended to be more rehabilitation oriented.

Results from two studies carried out for this Report suggest that casemix accounts for some of the cost differences between hospital-based and freestanding SNFs. Shaughnessy (1984) estimated that casemix differences between hospital-based and freestanding SNFs may explain up to 50 percent of their cost differences, while Sulvetta and Holahan (1984) estimated that 43 percent of the cost differences were due to casemix and staffing.

Conclusions

The Department conducted a thorough analysis of internal administrative data, reviewed existing literature and commissioned outside studies to provide the most complete picture currently available on the Medicare SNF industry. Our analysis of the available information indicates, however, that important issues need to be considered before specific options for reimbursement reform of the Medicare SNF benefit can be addressed.

A key issue is that no reliable and valid patient specific casemix measure presently exists for Medicare SNF patients. While the research presented in this report described the state of knowledge on the relationships between casemix and resource consumption of Medicare SNF patients, it is clear that further work is required.

A second major issue is the effect of hospital prospective payment on SNFs and other postacute benefits under Medicare. Since hospital payment under Medicare is on a per case basis, hospitals will have incentives to keep patients in an acute care setting only as long as is medically necessary. Thus, some observers predict that hospitals will discharge more patients to Medicare SNFs and other postacute units, such as rehabilitation hospitals and "swing beds." Because the Medicare SNF patient appears in many cases to ressemble a beneficary cared for in a rehabilitation setting and/or a hospital swing bed, though all three types of post acute care are currently reimbursed at different rates and according to different rules, the examination of reimbursement alternatives for SNFs should also take into account these related forms of postacute care.

Finally, the quality of care for Medicare beneficiaries needs to be ensured under any SNF prospective payment system. The Department is engaged in research and operational initiatives that are intended to improve our ability to examine patient outcomes to assure quality of care.

Results from our current research and operational initiatives should provide additional information to address many of the unanswered questions. This additional information will be incorporated in our analysis of specific SNF payment reform proposals which, as required by the 1984 Deficit Reduction Act, will be forwarded to the Congress in a separate report.

47-533 O—85——3

The CHAIRMAN. Your report points out the problem of access to skilled nursing facilities being experienced in many areas of the country right now. One, in your judgment how serious is the problem? And two, if serious, what can be done about it in the short term?

Dr. DAVIS. As I mentioned in my testimony, it seems that it is only scattered in terms of access and that most of the studies on hospital backup indicate that it is not related necessarily to patients seeking Medicare placement.

The CHAIRMAN. You say it is only scattered?

Dr. DAVIS. It is only scattered, and the majority of time, it is Medicaid placement that is the holdup. The fact that there is low-bed availability and low use rates in some areas of the country, I think, probably correlates most specifically with the certificate of need process.

The CHAIRMAN. Are you saying basically that as far as Medicare is concerned, you don't think there is a serious access problem except in a few isolated areas?

Dr. DAVIS. That is right. Tnat is what our data so far have shown.

The CHAIRMAN. Dr. Davis, almost all reports including this one that we requested from your agency are months, and on occasion years, late. I obviously cannot hold you responsible for the sins of your predecessors, but as chairman, I am very concerned. We ask for these reports, and the deadlines we give are based upon a schedule we would like to keep. It causes us either to delay taking actions that we think we might need to take, or we go ahead and do it without the report. Why—and this is especially true in your agency historically—are the reports late, and what can you do to increase the timeliness of them?

Dr. DAVIS. We do try to place a very high priority on getting our reports out on time, Mr. Chairman. I think the lateness is due to several factors. The volume of reports required at any one time has grown rather significantly. When we recently looked at our research agenda, we found that whereas in 1981 or 1982 we only had a few reports due to Congress, we now have about 40 percent of research effort that is specifically for congressional reports. And that is a significant increase over time. The volume that is required at any one time has been fairly great. I think it has been predominantly related to the Social Security Amendments of 1983 when we actually initiated the hospital prospective payment system. There were 11 reports that were given to us at that time, and then the DEFRA contained another 16 reports. Unfortunately, they all seem to come due at once, too. I can understand that because we are making major changes, particularly in relationship to the hospitals prospective payment system, we needed to study that and make some refinements and adjustments. Sometimes, the timeframes are too short for us to actually collect and analyze the data. Let me give one example of that. Last year the DEFRA legislation asked for a study to be reported on September 1, and I believe the legislation wasn't signed until July. That was a very complex study, asking us to look at the degree of variation in the in-patient cost within each DRG. That is a significant workload that would take us about a year to do. So, I think sometimes there is a need to be

more realistic in terms of deadlines. At other times, it is an area where we get into, and then we find the complexity of issues as they begin to be looked at means that we have to go even further in terms of our research activities. A good example of that is the whole development of a skilled nursing facility casemix index.

The CHAIRMAN. How soon do you think we can get your report on the options and recommendations for reimbursement reform of skilled nursing facilities?

Dr. DAVIS. On the skilled nursing facilities, as I mentioned in the testimony, we will be having some of our reports coming in this fall, including the report from the Rensselaer Institute in relationship to the development of what we call the resource use—relative utilization groupings or the RUG's groups for Medicare patients. We will have our first data base this fall on that. Now, that will give us some idea as to whether or not the RUG system will work. We then will need to take that data—since it is only based on 1,500 patients in 5 States, and I think 40 facilities—and apply that more broadly for a national representative sample. We will need to do some adjustments in our cost report in order to get that data. So, it will take us probably an additional length of time in order to gather that data and use it to actually implement such a program. I think once we have the data reports in this fall, we will be in a better position to assess whether it is realistic to even expect that a RUG system would work.

The CHAIRMAN. Let me ask you this. One of the arguments we will often get, or defenses we often get, is something like: We sent it to HHS several months ago, and nothing has happened to it. Or they will say: We sent it to OMB 3½ months ago, and it hasn't come back yet. What would you think if we were to require reports from you of simply when you sent the report along and to whom? I don't mean inside HCFA, but when you finally send it to somebody else.

Dr. DAVIS. Since all of these reports are secretarial reports, it is of course important that each one of the staff offices that support the Secretary have an opportunity to look at them and comment.

The CHAIRMAN. I have no objection to their commenting. My objection is that when we call up the Secretary of the department, she will say, HCFA had that for 6½ months and we have only received it, and we haven't had a chance to review it. This kind of answer is almost endemic to any agency that you are asking.

Dr. DAVIS. I think you might find the results of some interest, but I am not certain it would help speed up the process. Some of the issues are rather complex, and we find that although we have had a report that has been sent forward, occasionally once it moves to the next level, there is a need for verification of data or there may be a need for clarification of a section so that it is returned to us for a rewriting. Those are the kinds of things that do go on.

The CHAIRMAN. One last question because I want you on the record once more. Some of the subsequent witnesses may question it. Do you think there is no access problem by and large in skilled nursing facilities for Medicare patients except on a random geographic area basis and therefore not an overwhelming problem.

Dr. DAVIS. It does appear from our data to be that way. I think it is important to recognize that in the small rural areas, we have

had a very large increase in our swing bed requests and approvals. There are now, I think, up to 456.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Carolyne, many of the nursing homes cite the cost reporting requirements as one of the major deterrents for participation in Medicare. Can you tell us why the cost reporting is a burden and what we can do to ease up the cost reporting load? And then, in connection with the information—the cost-related information—that is being generated, would some of it be helpful? Is more of it needed in developing a prospective payment system?

Dr. DAVIS. I think the reason why it is such a heavy burden is, remember, that although many of the facilities are approved for the Medicare program, very few patients in each one of those facilities do actually get paid from that account, except for approximately 400 where there is the heaviest load. So, many of the facilities feel that they are filling out the cost reports for a very small number of dollars and a very small number of patients. And I can understand that from their point of view. That is an additional burden for a very small amount of money. I think from our point of view the data is necessary, however, particularly at this crucial point in time when we are trying to collect the data. Indeed, we may have to ask for some additional facets of information as we move to collect all of the data for a year or two to move towards a truly resource-oriented use type of system. So, I am afraid that, if anything, we would probably find the need for more data for a short period of time.

Senator DURENBERGER. With regard to resource utilization as applied to specific kinds of treatment?

Dr. DAVIS. That is right.

Senator DURENBERGER. Is there anything that we are requiring now that you think we shouldn't be requiring? Are we part of the burden—that is part of my question.

Dr. DAVIS. We would have to take another look at the report. I don't know of anything specific. I would be happy to go back and look at it. I think we probably would.

Senator DURENBERGER. Let me ask you another question about fiscal intermediaries—the wide variation according to the report—in how they interpret the Medicare SNF benefit and coverage decisions. Is there a reason why the SNF benefit is difficult to administer? Will the proposed regulations to eliminate the waiver liability for claim denials be still a further deterrent to SNF participation?

Have you thought about reducing the number of fiscal intermediaries for SNFs, similar to what we are doing for home health providers?

Dr. DAVIS. I'll answer the last question and then move backwards—there were a number of questions there. I don't think we have really thought necessarily about the need to move to concentrate the fiscal intermediaries who are handling this skilled nursing facility benefit. I suppose it could be done for the freestandings. For the hospital based, we probably would find that they would want to be definitely using the same intermediaries as they did for the hospital part. Otherwise, it would be an excessive reporting burden for them. We can certainly take a look at that. I think your question in relationship to the waiver of liability and would that

impact on the access problem—we don't believe it will because actually all we are doing in that waiver liability regulation is to suggest that we would need to review it under a claim-by-claim process, rather than to simply pay for claims that are not appropriate. It seems to us at this point in time when we are looking for every dollar of savings, that it is not appropriate to pay for services in the areas where the individuals are expected over time to be familiar with the appropriateness of placement. However, we do have a work group. I just recently formed a task force inside my agency to look at the variation that we might need to consider in relationship to that waiver of liability as it applies to the different provider groups. It may well be that different provider groups have different problems. So, we will be looking at that before we make any final decision on that waiver of liability.

Senator DURENBERGER. All right. You have said it is difficult to develop a prospective payment system SNF, but I need just a little bit of an idea in a very brief time what kind of thinking you are doing already on prospective payment. Have you laid some groundwork by thinking how it would affect the current distribution of the SNF benefit or the behavior of the nursing home industry? In a general way, are you able to say that it really isn't worth thinking about, or yes, we ought to explore it, or that it is sort of an imperative?

Dr. DAVIS. Oh, I think it is worth exploring. It is very clear from our point of view in exploring it that you have to have some measure of the heavy case. And the way to do that is our major puzzle at this point in time. As I indicated to you, we have two different tracks really. We have the development of the RUG's measurement, and then we are also considering bundling of the payment into the hospital DRG. And we will be going out to explore and to test both of those. We have the report with Rand right now, which is one of our policy centers, to develop the policies around which we would then move to implement a demonstration on the bundling of the SNF payment into the DRG system. There are some complex questions there, too.

Senator DURENBERGER. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Mitchell.

Senator MITCHELL. If I may follow up, Dr. Davis, on Senator Durenberger's line of questioning, do I understand that we will have the report on SNF payment reform proposals some time this year?

Dr. DAVIS. In relationship to our specific recommendations for the next phase? Is that what you are referring to, because the report did come in yesterday?

Senator MITCHELL. Yes, I understand that, but although it dealt with reimbursement issues——

Dr. DAVIS. It did not contain recommendations.

Senator MITCHELL. Right.

Dr. DAVIS. Because we felt we needed time yet to analyze where we should move in the future on that. Clearly, once we have seen the data that comes in this fall, we will be in a better position to at least make some other assessments, but in terms of which system to actually recommend, I don't believe that we would be in a position to do that this year. I think that would depend very much on

our wanting to do some test demonstrations rather than to simply accept an idea that is as yet untested and move to implement it.

Senator MITCHELL. When might we expect recommendations on payment?

Dr. DAVIS. If you move to implement the demonstrations on the bundled hospital payment and the skilled nursing facility payment, it would probably take 3 to 4 years before we would see any definite results in terms of that kind of a bundle concept. Looking at the development of the RUG's——

Senator MITCHELL. I am not clear on this. Are you saying it will take 3 to 4 years before you are in a position to make any recommendations on payment reform?

Dr. DAVIS. I am saying that it would take 3 to 4 years before we would be certain enough as to the outcomes—the impact on quality, the impact on access, all those things—to feel comfortable recommending a specific prospective payment system that takes into account casemix index in some measurable way, either through a bundled program such as we have talked about to integrate the skilled nursing facility payment into the hospital payment DRG or, alternatively, a separate payment system that has what we call a resource utilization grouping. In other words, it pays differentially according to the amount of resources that you use to take care of that payment. That does seem to make a difference, but we have only seen it in a very small sample at this point in time. And before we would feel comfortable moving to a nationwide system, we would feel the need to definitely demonstrate that.

Senator MITCHELL. I was going to recommend to you a number of factors to include in your consideration of a prospective payment system, but I am afraid that since it is 3 or 4 years off, you will forget them by then.

Dr. DAVIS. What we could report on, Senator, is the success as of late fall or early winter in terms of where we are—the status on both of those. We would be happy to do that. It would be an interim type of report, however. It would not be, I think, possible for us to take a position that we should favor a nationwide implementation of one versus the other without having done some further studies. But we certainly could clearly report further on what we know about the success, keeping in mind that the development phase—the development of the RUG's, or the resource utilization groups—would only be based on 40 facilities and 1,500 patients, and that is not enough to give us confidence to implement a system nationwide. I think it is important to remember that whatever we do in moving to a prospective payment system, hopefully in the end what we are trying to get to is a system that would recognize that different degrees of illness do need different amounts of resources. To not recognize that, I think, would really mean that we are not answering one of the major problems that we have right now, and that is that the heavy duty type patients are the ones that sometimes are not welcomed because——

Senator MITCHELL. One of my recommendations is going to be that you consider including an acuity factor in establishing this. I gather from what you say that you think that would be a good idea?

Dr. DAVIS. Yes, I do, and that acuity factor is in effect what we are trying to measure as we look at the whole issue of resource utilization groups. That is what the research is getting at. It seems to us that the major thing that seems to impact, as we have looked at the studies, has been the activities of daily living—whether or not you need to have somebody help you with your feeding, whether or not—you know, all of those types of activities. They seem to impact much more than the diagnosis itself.

Senator MITCHELL. I would also like to suggest that you take into account the situation in the States that are rural with no dense concentrations of population where you have a lot of facilities, both hospital-based and free standing, that are small in the number of beds and which cannot take advantage of the economies of scale of larger units. The same problem, of course, is being encountered in the DRG system for such hospitals, and I hope you will look at that very carefully.

Dr. DAVIS. We will certainly do so. Again, I think that stresses the need for demonstrations, to make certain that any system that we put in place would not unduly penalize one group versus another.

Senator MITCHELL. As well as regional differences involving weather, heating requirements, and so forth. My time is up. Thank you.

The CHAIRMAN. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman. Dr. Davis, I would like to follow up on the last point Senator Mitchell made, particularly about the need in rural areas. It is more and more difficult for people in rural areas these days, and it is not only because of health care access. The administration also proposes that cuts be made in other kinds of services and that makes it even that much more difficult to decide on health care. So, I urge you very strongly to follow up on rural considerations. I was interested in your statement that so far your data shows that there is not much of a problem with Medicare patients getting access to skilled nursing facilities. It is my understanding that some skilled nursing facilities cannot take Medicare patients. This is partly because Medicare pays less, and the Medicare patients tend to be less sick, and also private plans pay a little more than Medicare. I am wondering if you could flush out for me where you see some problems of access for Medicare patients to skilled nursing facilities and where not. If you could just expand that a little bit, please.

Dr. DAVIS. I will have to submit for the record in terms of specific geographic areas because I can't name any——

Senator BAUCUS. If you could just give me some of your general impressions

Dr. DAVIS. Let me give you some general impressions.

Senator BAUCUS. Surely.

Dr. DAVIS. First of all, I think it is important that, as you know, many of the rural areas do have swing beds, and we have seen an enormous growth in swing bed facilities.

Senator BAUCUS. That is right. I have talked to a lot of administrators at some of these facilities, and they appreciate that.

Dr. DAVIS. There has been a very dramatic increase, from I think 130 before prospective payment, to 450-some now, but it is impor-

tant to recognize that Medicare only has a very small component of patients in most facilities, many of your facilities prefer to take—in the nursing home area—the Medicaid patient because they are staffed for the Medicaid patient. Although Medicare in general tends to pay more, it is true that the typical Medicare patient also demands more services—more rehabilitation services, more medical-type services, and services of that nature. I think that when you look at the variation in the use rate of Medicare benefits around the country, there is an enormous variation pattern.

Senator BAUCUS. Now, what explains that variation? I have heard statements that there are fewer than 400 facilities that provide 40 percent of the total Medicare days and the vast majority provide the fewest Medicare days. What is the reason for that vast gulf?

Dr. DAVIS. I think there are probably several. No. 1, I think there is an enormous variation in practice patterns, patterns of referral into nursing homes. Some areas of the country believe that it is an important benefit, and they construct more nursing homes than others. That gets us back to the degree of tightness, if you would, in a certificate-of-need process. Some States have certificate-of-need processes and others don't. For those States that have a very restrictive certificate-of-need process, it may be that it is less easy for them to invest in new facilities.

Senator BAUCUS. But doesn't that suggest that there is an access problem?

Dr. DAVIS. It depends. If the practice patterns in that area mean that they are accustomed to taking care of their people at home, or through homes and community-based services or through home health care or something like that, they may not feel they need those beds, whereas in another area of the country, they may need more. And we see that if you look at the use, the pattern of usage is quite different around the country.

Senator BAUCUS. Finally, I would like to just voice some frustration. I understand it takes a long time to get things done the right way. Anything worth doing is worth doing well, but I am a little perplexed why you have been working at this for several years and why it is going to take several years more. I know the prospective payment system took some time to develop. After all, though, I think that PPS has probably provided some experience in this area to some degree. You have the benefit of that. You don't have to go back and totally cover all that ground. So, I would just encourage you to try to push forward a little faster than 3 or 4 years, maybe crank it down to a couple.

Dr. DAVIS. I would be happy to provide interim reports as we go.

Senator BAUCUS. That would help, too. Thank you.

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. My question touches somewhat as a natural follow-up of what Senator Baucus just said, and that is if you go the direction of an alternate reimbursement system, whether or not we can avoid those pitfalls in the inequities that maybe you would see more in the Midwest and mountain regions between the rural and urban facilities. And we had those problems with the hospitals, and they have been addressed a little bit by HHS, but nothing from my standpoint like I think they should. I think there

is still a t rrible inequity between urban and rural hospital reimbursement, and so the extent to which you can avoid that in the case of skilled facilities, do you think it can be avoided, or maybe you don't accept the fact that there is an inequity between the rural and urban hospitals? But if you did—or maybe there could be in the case of skilled facilities—can that be addressed so we don't have that inequity?

Dr. DAVIS. I think we did clearly learn several things as we implemented the prospective payment for hospitals. As you well know, the area wage index was one of the things which we had used before, and we simply continued to use it. We discovered that once we were using it as a more finite measure, there were differences that needed to be corrected related to part-time and full-time employees, and we have just completed that report. Clearly, we would learn from that. I doubt that we would have that same degree of utilization of part-time and full-time employees in the nursing home industry. We can clearly look at that ahead of time, but I think equally important to remember is that when we sent the report to Congress on prospective payment for hospitals, we did not have a differential. We did not have any recommendation that spoke to the difference between urban and rural That was something that I believe was a congressional decision. So, it does take our mutually working together as we explore these kinds of movements. And that is why I think it is important for us to do demonstrations to make certain, before we would apply a nationwide casemix index system. We need the time to analyze whether or not there are differences between the use patterns in rural and urban areas and whether or not the diagnosis makes a more significant difference than what we can determine at this point in time. The internal analysis that we have done—and we have only been working on it admittedly for a couple of years time—would indicate that the DRG alone is not enough to make a determination in terms of the use of resources in the skilled nursing facility part. I think it is important, too, to remember that since Medicare skilled nursing facility payments are only 1 percent of our total dollars, of necessity we gave much more time and attention over the first few years to the development, design, and implementation of prospective payment for hospitals. Once we got that started, we then shifted our emphasis and are now beginning to apply some of our resources to the development of a prospective payment system for skilled nursing facilities, but it will take time.

Senator GRASSLEY. Thank you. When you made your statement that it was Congress and not the proposal from the administration that caused this to end up with a rural-urban differential, then are you saying that if there is an alternate proposal, then you wouldn't have a rural-urban differential, and the suggestion from the administration?

Dr. DAVIS. In relationship to?

Senator GRASSLEY. Skilled nursing facilities.

Dr. DAVIS. I think we would want to take a look at that proposal when it came in. I can't speak ahead of time for that. I simply don't have the data to make a decision just yet.

Senator GRASSLEY. All right. Then, I guess I would leave you with this thought: If you do, then we have the hospital trial balloon

to learn from, and maybe even if you would suggest that there shouldn't be, for whatever reason, Congress decided to put one in in the case of the hospitals, they may decide to do it for the skilled facilities and help us to avoid any pitfalls as well. Mr. Chairman, in closing, could I have permission to put a statement in the record?

The CHAIRMAN. Without objection. Senator Long.

Senator LONG. No questions, Mr. Chairman.

The CHAIRMAN. Senator Durenberger, any other questions?

Senator DURENBERGER. Just one, if I may, Mr. Chairman, while Carolyne is here. I just read in one of the many health newsletters around that you are contemplating a regulation to limit direct medical education expenditures under Medicare as of July 1 and that you are going to use a 1983 base—the cost report data base—which seems to me that it would not. First is this true? And to use 1983 cost data, it seems to me you are not freezing or rolling back—do you know anything about this?

Dr. DAVIS. I know about it. I don't think there has been a final decision in relationship to the data base year.

Senator DURENBERGER. But you are coming up with a regulation that would freeze——

Dr. DAVIS. We will be looking at a way to contain the costs under the direct, yes. That is part of the proposal that we——

Senator DURENBERGER. Are you looking at a freeze?

Dr. DAVIS. Yes.

Senator DURENBERGER. Are you going to try to reduce costs?

Dr. DAVIS. That is our hope, yes.

Senator DURENBERGER. All right.

The CHAIRMAN. Are there any other questions?

[No response.]

The CHAIRMAN. If not, Dr. Davis and gentlemen, thank you very much.

Dr. DAVIS. Thank you.

The CHAIRMAN. Next we will have a panel of Mr. David Glaser, the executive vice president of the Jewish Institute for Geriatric Care, on behalf of the American Association of Homes for the Aging, and Dr. Paul Willging, deputy executive vice president of the American Health Care Association. Mr. Glaser, why don't you go first? Again, your testimony will be in the record in full. We would appreciate it if you would abbreviate it. If you will notice the lights, when the yellow light goes on you have a minute left.

STATEMENT OF DAVID H. GLASER, EXECUTIVE VICE PRESIDENT OF THE JEWISH INSTITUTE FOR GERIATRIC CARE, ON BEHALF OF THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING, WASHINGTON, DC

Mr. GLASER. Thank you, Senator. Good morning. I am David Glaser, and I am the executive vice president of the Jewish Institute for Geriatric Care in New Hyde Park, NY. It may interest you to know that this not-for-profit skilled nursing facility—freestanding facility—averages 28,000 Medicare days per year, and discharges home about 65 percent of its admissions, and these are Medicare admissions. With me today is Mr. Howard Bedlin, on my

right, reimbursement policy analyst for the American Association of Homes for Aging. For those skilled nursing facilities that have problems dealing with the current system of retrospectivity, the Covernment should not view this system as inflationary. Since 1967 SNF expenditures have decreased to point where they are now less than 1 percent of Medicare spending. It should also be noted here that SNF costs have been rising at a rate below that of inflation in the industry. I believe this committee should be addressing itself to what I see as a national crisis in the making, and that is the impact that the hospital DRG's are having at the skilled nursing facility level. The DRG's have indeed had a desired impact on hospital cost containment but at what human expense at the skilled nursing facility level? Statistics contained in our prepared statement clearly show a dramatic shortage of SNF Medicare beds across this country. Skilled nursing facilities are now not only confronted with a reimbursement system that fails to meet current needs, but are asked to admit patients with an increasing number of medical problems. Several studies show that DRG patients are leaving hospitals in a sicker state of health than before and with fewer nursing home beds available. Medicare patients are being discharged into a vast no-care zone without access to appropriate care. In examining the skilled nursing facilities low participation in the Medicare program, several reasons come to mind. Congress intended that section 223 cost limits would impact relatively few institutions. HCFA has reported that 35 percent of the SNF's in the country were hitting these limits in 1984. I think this is contrary to congressional intent. The cost limit exception and appeals process is arbitrary, unreasonably restrictive, and characterized by excessive delays. I can personally attest to my own still-unresolved experience with this process. The current cost reporting system for most homes is unreasonably excessive and complex for the majority of homes with relatively few Medicare patients, and this is the report that we must fill out at the end of each year, if you want to take a look at it—it is horrendous. Medicare coverage determinations are very inconsistent and imprecise and biased. If a recent proposed rule which would eliminate a favorable presumption of waiver of liability is issued in final form, I am concerned that providers would shift costs to beneficiaries. The fact that so many providers are losing money for every day they treat a Medicare patient presents the greatest obstacle to participation. In general, one of the best methods by which access can be advanced to a reimbursement system is to make adjustments for casemix. Since different patients have different needs, it is essential that a prospective payment system for skilled nursing facilities account for these differences and allow for quality patient care by varying rates according to resource needs. Without casemix adjustments, providers would have incentives to take only the lightest care patients. Whatever payment system is ultimately adopted, it is essential that it not reward low quality. In this regard, AAHA is opposed in the strongest terms to a system which pays flat rates for services or items which affect the quality of patient care. Prospective casemix adjusted ceilings must be set within homes should be reimbursed for actual costs incurred. It is equally important how various items and services are paid for within such a structure. Items

directly related to quality patient care ought not have the same ceilings and incentives as other services having little or no effect on patient care. We encourage a system with four cost centers—direct nursing care, other patient care, administrative and general services, and capital. These cost centers are detailed in our prepared statement. Unfortunately information is not yet available to implement the patient-based casemix reimbursement system. However, data is being collected at this point, which should be available, as we heard, this fall. We can't wait until next year to address the many serious problems discussed. We must act now in the best interests of the elderly. The only logical prospective system we could adopt immediately is one in which it pays facilities according to their historical costs, adjusted by an inflation factor. Such a methodology would promote cost containment and would not provide incentives for providers to reduce quality care to the extent that a flat rate would. Another advantage of this proposal is that many homes are already familiar with working under such a methodology. May I conclude in another 10 seconds?

The CHAIRMAN. Yes.

Mr. GLASER. Members of AAHA, all or not-for-profit agencies, exist for only one purpose, and that is to serve the frail elderly. It is difficult for us now to meet the needs of this population. Introducing a prospective payment system that does not adequately pay for patients' more acute care needs at the SNF level will drive many providers either completely out of the program or will result in drastic reduction in beds, services, and quality patient care. Thank you.

The CHAIRMAN. Thank you. Dr. Willging.

[Mr. Glaser's prepared written statement follows:]

STATEMENT BY DAVID H. GLASER

The American Association of Homes for the Aging (AAHA) appreciates this opportunity to express its views on prospective payment for skilled nursing facilities (SNFs) under the Medicare program. As the national representative of 2,500 nonprofit skilled nursing facilities, intermediate care facilities, housing, other health-related facilities and community services for the elderly, AAHA is vitally concerned about the SNF Medicare program. Our members are sponsored by religious, fraternal, labor, private and governmental organizations committed to providing quality services for their residents and for elderly persons in the community at large.

The current SNF Medicare program is seriously flawed, creating problems of crisis proportions. The post-hospital health care needs of America's elderly population are not being met, and the situation is growing rapidly worse: harsh disincentives to participation abound at a time when consumer demand is escalating at an unprecedented rate because of demographic trends and the impact of the new hospital DRG prospective payment system. The concern of both providers and beneficiaries is heightened because many states adopt Medicaid reimbursement systems based on Medicare principles.

BACKGROUND

While the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) directed the Department of Health and Human Services (HHS) to develop recommendations on Medicare prospective payment systems for both hospitals and nursing homes by December 31, 1982, only the hospital report was delivered at this time. The SNF report was delayed for good reason: relevent information was severely lacking. Despite more than two year's additional preparation time, the report does little more than describe characteristics of the

current SNF Medicare program. Although the report contains extensive and useful data, it does not provide sufficient knowledge to move ahead with a DRG-like payment system which could be applied to the Medicare SNF population. Unlike the situation for hospitals, diagnosis by itself is not a significant indicator of costs in the nursing home industry. A great number of nursing home residents have multiple diagnoses, many of which are unrelated to the diagnosis necessitating hospital admission. This makes it impossible to apply fairly the hospital payment system to nursing home patients. Research is currently underway to collect the kind of information that could lead to an equitable prospective payment system for Medicare skilled nursing facilities. This patient specific data is likely to be available in rough form by Fall of this year.

The original motivation behind the request for these reports was the legitimate concern about the predicted bankruptcy of the Medicare trust fund. In early 1982, health care economists were projecting that the trust fund would be depleted by as early as 1987. Alarming increases in Medicare hospital expenditures in excess of the general inflation rate, spurred interest in new methods to reduce spending and save the trust fund. Thankfully, the new DRG system is working and projections on the insolvency of the Trust Fund have been extended ten years.

Even before the DRG system was enacted, however, nursing home costs never contributed to the Medicare cost containment problem. Expenditures on nursing homes now constitute less than one percent of total Medicare spending--down from 6.2 percent in 1967--significantly lower than payments to physicians or home health agencies under the program, and even lower than the error rate in payments to hospitals. Additionally, unlike hospitals, increases in Medicare

expenditures and per diem costs for SNFs have been consistently below the rate of inflation in the industry. Without question, cost containment has not been a problem in the SNF Medicare benefit.

Since the present system is not inducing unnecessary cost inflation, AAHA does not believe that retrospectivity by itself is the primary problem with the present payment methodology. Although some research has shown that prospective systems tend to contain costs more than retrospective systems, the current methodology is holding down costs through the use of very restrictive caps, known as Section 223 cost limits. While the ideal system certainly should promote the efficient delivery of quality services, the cost limits are arbitrarily capping the rates of over one-third of all SNF Medicare providers; motivating them to deny admission to heavier care patients ("cream-skim"), to avoid incurring the costs necessary to provide quality care, and to reduce their Medicare census because of the losses incurred, thereby reducing access to needed services. The primary issues, therefore, are not cost containment or prospectivity, but improving access and quality care without permitting waste, inefficiency, and excess profits.

ACCESS TO SNF MEDICARE SERVICES

The data reveals that serious access problems exist for older Americans. SNF Medicare covered days per 1,000 elderly beneficiaries declined by over 21 percent between 1976 and 1982, dropping from 413.84 to 324.19 covered days. Since the number of persons over age 65 has risen significantly in that time, with an expected concomitant increase in demand, the reduction in covered SNF Medicare days suggests that availability of these services has declined at an alarming rate. Another shocking statistic reveals that total covered days

were reduced by over one-half between 1969 and 1977, dropping from 14.4 to 7.1 million days. Without barriers to access, Medicare beneficiaries' covered days surely would have increased.

The shortage of SNF Medicare beds is even more severe in certain parts of the United States. In 1982, 42 states had fewer than ten nursing homes with an average census of at least 16 Medicare patients; 30 states had less than five such Medicare-oriented facilities; while twelve states had no such facilities. In 1980, one-half of the non-metropolitan counties and 17 percent of the metropolitan counties lacked any certified skilled nursing facilities. In that year, over half the elderly population in five states (Iowa, Louisiana, Nebraska, New Mexico, and Oklahoma) lived in counties without SNFs; in another eight states more than one quarter of the elderly were in similar circumstances. The proportion of the elderly living in rural areas without SNFs exceeded 50 percent in eleven states and over 80 percent in four states.

These figures reveal only a small part of this dangerously increasing undersupply of needed services. Of major new concern is the skyrocketing demand for SNF Medicare services that has arisen as a result of the new hospital DRG prospective payment system. By providing incentives for hospitals to discharge patients much earlier than before, the DRG system has caused a tremendous increase in beneficiaries' need for post-hospital rehabilitative SNF Medicare services. DRGs are working, as length of stay in hospitals has declined from 9.5 days to 7.4 days in the past year. Three studies have documented the greater pressure nursing homes are now under to admit discharged hospital patients.

The National Center for Health Services Research found, "About 70 percent of discharges to nursing homes stayed beyond the average for their DRGs

their DRGs compared to only 48 percent patients with a regular discharge period. Elderly Medicare patients needing long term care services would account for about nine days of unreimbursed care per discharge compared to three days for a patient discharged to self care." The report documents that many patients discharged to nursing homes required a longer than average stay in the hospital and, therefore, would have been financial "losers" for the hospital. Clearly, such patients are much more likely to be discharged prematurely.

A second recently released study, conducted by the U.S. General Accounting Office at the request of the Senate Special Committee on Aging, reports "patients are being discharged from hospitals after shorter lengths of stay and in a poorer state of health" than before DRGs were in place. The report also noted that, with some exceptions, nursing home beds for early hospital discharge are not readily available. The study concludes, "We believe that the issues discussed in this report are sufficiently important to warrant HHS studies that will assess problems in access to and quality of post-hospital services supported by Medicare."

Finally, a survey conducted by the House Select Committee on Aging found that patients are leaving hospitals sicker and are requiring more post-hospital care since the enactment of the DRG system. Respondents to the survey, long term care ombudsmen in all 50 states, indicated by an overwhelming margin of 77 percent that patients have been leaving hospitals in sicker condition since the enactment of the DRG payment system. 71 percent of those responding also said that "more to many more" discharged patients require skilled nursing care after leaving hospitals.

These three studies document a situation of great urgency: elderly Medicare patients are being discharged into a rapidly expanding no-care zone; denying access to the kind of health care they need. If Congress fails to act quickly, literally thousands of elderly Americans will be denied the services they were assured under the Medicare program. Should hospitals be squeezed to a greater degree by the denial of reasonable inflation adjustments (as has been suggested in the current Medicare budget freeze proposal) their incentive to discharge patients prematurely will only increase. The logical response to this skyrocketing demand is to increase incentives for nursing home participation in the Medicare program. Currently, such incentives simply do not exist.

BARRIERS TO PARTICIPATION - MEDICARE'S BROKEN PROMISE

Providers simply have no reason to participate in the SNF Medicare program because of numerous, harsh disincentives. The SNF Medicare program is an illusion; a broken promise which cannot honestly be referred to as a "benefit". There are ten valid reasons why providers are discouraged from participation. They are:

(1) Cost Limits--Despite the fact that Congress, in enacting the Section 223 cost limits, stated that the limits would apply "to a relatively quite small number of institutions" and only in "cases with extraordinary expenses", the Health Care Financing Administration (HCFA) has reported that 35 percent of the SNFs in the U.S. were hitting these limits in 1984. This percentage will, no doubt, be higher this year due to the higher cost of care needed by patients discharged under the hospital DRG system. Such a broad application of Section 223 is clearly contrary to Congressional intent.

(2) Cost Averaging--The current reimbursement system is essentially an averaging process of per diem costs of each provider's overall patient population, including residents being reimbursed under the Medicaid program. Since this method averages in the lower routine costs for treating Medicaid patients, homes are reimbursed for significantly less than the amount it costs to treat Medicare patients.

(3) Impact of DRGs--SNF Medicare reimbursement rates have not been adjusted to realistically reflect the more expensive care required by the sicker patient population being discharged under the DRG system. These very different beneficiaries have an urgent need for post-hospital care.

(4) Exceptions and Appeals--The cost limit exception and appeal process is unreasonably restrictive and characterized by excessive delays which often serious cash flow problems because years pass before exception or appeal determinations are made. Standards for formulating peer groups are unwritten and often arbitrarily determined.

(5) Cost Reporting--The cost reporting burden, particularly for the large majority of homes with relatively few Medicare patients, is unreasonably excessive relative to program benefits. Failure to meet precisely these complex and voluminous reporting requirements also provide reason to deny payment for insufficient documentation.

(6) Coverage--Medicare coverage determinations are grossly inconsistent, imprecise and biased. Intermediaries have financial incentives to deny coverage. Frequent denials of days submitted for coverage can leave providers at risk for payment. If a recently proposed rule to eliminate a favorable presumption of waiver of liability is issued in final form, this problem will be grossly exacerbated. Providers would have incentives not to submit claims and to shift costs to beneficiaries.

(7) Retroactive Denials--A rash of retroactive denials occurred between 1969 and 1971, forcing over half of the nursing homes in the country to drop out of the Medicare program. These retroactive denials imposed severe financial penalties for homes and resulted in substantial losses which left a lasting impression on many now unwilling to "risk" participation. Confidence in the program has never been the same.

(8) Consumer Ignorance--A large majority of beneficiaries falsely believe that the SNF Medicare benefit provides full payment of 100 days of care. In reality, an average of only 29 days is covered, and from the 21st day to the maximum 100th day beneficiaries are charged with a $50 copayment (over two times greater than the approximately $20 Medicare pays for services during that time). Many providers strongly object to being placed in the position of having to inform disheartened residents of these coverage restrictions and out-of-pocket charges.

(9) Waiting Lists--Because demand far exceeds the supply of available nursing home beds, waiting lists average 32 persons. This makes it extremely difficult for most skilled nursing facilities to admit in a timely manner Medicare patients ready for hospital discharge.

(10) Prior Hospitalization Requirement--The three day prior hospitalization requirement restricts flexibility and is unnecessarily burdensome. In certain instances, the requirement unnecessarily delays admission to the nursing home and generates avoidable paperwork in the transfer process.

Unless these considerable problems are addressed, providers will refuse to participate in the SNF Medicare program and access to needed services will be severely restricted. The no-care zone following a hospital stay will almost surely expand; inhibiting patients' rehabilitation, putting undue pressure on families forced to render care they are ill-equipped to provide, and necessitating placement in more expensive settings, thereby increasing total Medicare expenditures.

The fact that so many providers are, or would be, losing money for every day they treat a Medicare patient is certainly the greatest obstacle to participation. A prospective system which does not address this fundamental problem will perpetuate trends toward diminishing access to needed services. Merely redistributing funds within the same dollar constraints will have no effect on improving access for beneficiaries.

AAHA urges Congress to review its original intent in enacting SNF Medicare cost limits and to consider adjusting payments for the more intensive care needs of patients discharged earlier under the new DRG system.

Budgetary considerations should be viewed in the context of total Medicare spending, not solely SNF Medicare spending. Expansion of the SNF Medicare benefit will almost surely result in reductions in total Medicare spending; primarily for three reasons. First, if hospitals are unable to discharge patients appropriately, they are likely to keep the patient in the acute setting until a bed for discharge becomes available. As the NCHSR study showed, such patients are likely to become outliers, resulting in Medicare payments far above the rates paid to nursing homes under the program. Second, the hospitals may discharge the patient to an alternative setting, such as a rehabilitation hospital or a rehabilitation unit within a hospital. Again,

such facilities, which are exempt from the DRG system, are significantly more expensive than skilled nursing care, and are a cost inflating alternative. Finally, Medicare savings will be realized when the DRG system is rebased according to new cost data collected. Present rates were calculated on pre-DRG experience. If hospitals are able to quickly discharge patients to accessible skilled nursing facilities, hospital length of stay will be even more substantially reduced, resulting in concomitant budget savings upon recalculation of the rates. Alternatively, if access to post-hospital care is restricted, the new rebased rates will be unnecessarily high and fewer Medicare dollars will be saved.

Reducing the cumbersome cost reporting burden will certainly improve access for Medicare beneficiaries. Simplified cost reports have always been considered one of the primary benefits of a prospective system. A special short-form cost report for providers with infrequent Medicare utilization would be particularly beneficial, although it should include sufficient data to hold the industry accountable and to allow ongoing research. We strongly recommend that a task force be formed of representatives from HCFA, the industry, and consumers to achieve a balance in a design of a short-form SNF Medicare cost report.

A timely and consistent exception and appeal process would definitely improve access for beneficiaries. Exceptions and adjustments should be permitted for atypical needs of patients or other changes beyond the nursing homes' control. Adjustments made in response to the hospitals DRG system should be recognized, such as the addition of a significant number of staff, programs or services that were not previously in existence. Special consideration should be given to facilities with formal rehabilitation or a

relatively high proportion of full-time medical staff. Relevant criteria and statistical information used for comparative purposes should be provided to the facilities within 60 days of filing. Requests for any and all facility documentation should be made within 90 days of receipt of the application for exceptions. A determination should be rendered within 150 days of filing. Peer groupings for exceptions and appeal adjudication should be constructed on the basis of bed size, Medicare part A utilization, and similar geographic areas along the lines of the current Medicare wage indicies.

The problem of inconsistent and imprecise intermediary coverage decisions must be addressed. Most important, the presumption for waiver of liability must be retained. There should be a periodic official publication of the facts and coverage rationale for a representative sample of cases in the "grey" areas, including observation, assessment, and overall management of patients with multiple problems. This information should be made available to the general public. Statistics on the administration of the skilled care benefit by individual Medicare intermediaries should also be compiled to help facilitate intermediary performance review by HCFA. In addition, there should be a standardized program of training for intermediary personnel who perform these reviews to ensure that reviewers and their supervisors completely understand the criteria for coverage and the way these criteria are applied. We also urge that HCFA put together a task force to address the inconsistent administration of the SNF Medicare benefit and to help clarify what is and is not covered. Incentives for intermediaries to deny coverage should be eliminated. Written guidelines should be as specific as possible and intermediaries should be enccuraged to make firm prospective determinations of coverage. Coverage should formally be approved for specified periods of time

on or shortly after a patient's admission. Cases should be reviewed again when initial coverage periods expire. Such an approach might be similar to the "presumptive coverage" for a specific diagnosis that Congress authorized in 1972 legislation but was never required of Medicare intermediaries. Finally, an expedited review and appeals process should give immediate consideration to appeals of admission denials.

AAHA recommends that a public information campaign be conducted to inform older Americans of the limits on SNF Medicare covered services. Copayments should be reduced so that Medicare pays a greater amount than beneficiaries do from the 21st to the 100th day. The prior hospitalization requirement should be eliminated when it is neither necessary nor cost effective.

In general, one of the best and most important methods by which access can be advanced through a reimbursement system is to make adjustments for case-mix. Since different patients have different needs and characteristics, it is essential that a prospective payment system for SNFs account for differences between individual patients by varying rates according to resource needs. Case-mix adjustments will increase access to SNF care for those patients in greatest need of care because providers would be paid higher rates to admit sicker Medicare beneficiaries. Without case-mix adjustments, providers have incentives to take only the lightest care patients. According to the Urban Institute, well-known for its nursing home expertise, "Unless the reimbursement mechanism takes differences in patient conditions into account, homes are particularly likely to reject patients requiring expensive attention and treatment." If patients are to receive the services they need, the SNF Medicare reimbursement system must adjust for case-mix and adequately pay for the costs incurred in rendering quality care.

PROMOTING QUALITY THROUGH REIMBURSEMENT

Despite significant improvements in the quality of care over the past decade, the perception of the nursing home as an alternative of last resort persists. Undoubtedly, quality of care varies to a much greater degree in nursing homes than in hospitals. While health care experts agree that most, if not all, hospitals provide excellent care, these same experts will attest to the fact that quality of care in nursing homes varies from superlative to abominable. In formulating any new methodology for reimbursing nursing homes, incentives to promote quality of life and quality of care must be foremost on our minds. Since reimburesment inevitably structures incentives, it is essential that the system does not reward poor quality.

It is of utmost importance that nursing homes not be reimbursed by a flat rate system which fails to reflect the wide range in the type of patients served and the quality of services offered. A flat rate system would provide perverse incentives to deliver the lowest common denominator of care, seriously harming the health and well being of older Americans. As a General Accounting Office report stated, "Allowing a nursing home a fixed amount which does not consider the actual cost of operation may generate economic pressure on the nursing home (1) to reduce costs by sacrificing the quality of care provided or (2) to avoid incurring the increased costs necessary to improve the level or quality of care." The Urban Institute has also stated,..."flat rate reimbursement tends to reward the sacrifice of quality in pursuit of lower costs." A flat rate system would also overcompensate and subsidize the lowest quality facilities at public expense while forcing the best homes to either drop out of the Medicare program or shift costs onto private paying patients. Aditionally, flat rates might pay for services and items that homes

are not providing. This difference between what is paid for because it is expected to be provided, and what is actually provided by the home, could be substantial and unnecessarily increase federal expenditures. AAHA is adamantly opposed to a system which pays flat rates for services or items which affect the quality of patient care.

AAHA believes that one advantage of retrospective reimbursement is that it provides greater incentives to incur costs necessary to provide quality care. The ideal way to promote incentives for efficiency and quality is to combine aspects of both prospective and retrospective reimbursement. AAHA strongly recommends that the advantages of each of these systems be incorporated by reimbursing retrospectively within the constraints of prospectively set ceilings. Such a system would be similar to the Ohio and West Virginia Medicaid methodologies. Cost containment and efficiency would be encouraged by case-mix adjusted prospective ceilings on reimbursement rates, while quality of care would be encouraged by only paying for services actually delivered. Additionally, different services and expenses should not be treated similarly for purposes of reimbursement. Items directly related to the quality of patient care should not be subject to the same ceilings and incentives for efficiency as other services which have little or no effect on patient care.

We encourage development of a system with four cost centers: direct nursing care, other patient care, administrative and general services, and capital.

Direct Nursing Care--By far the most important cost center is the one including direct hands-on services and therapies. This is the cost center

that is influenced by and must be adjusted for case-mix differences between facilities. The system must be patient-based so that providers will have incentives to admit heavier care patients.

At this time, information is not available to enable us to articulate precisely which factors should be used to develop the case-mix system. Until patient-specific data is collected and homogenous resource consumption groups are formed, it is difficult to project what criteria to use in formulating case-mix categories. We speculate that significant factors might be dependencies in activities of daily living and the need for special services and therapies, such as decubitus ulcer care, tube feeding, ostomy care, I.V. care, suction/tracheotomy, oxygen-aerosal therapy, chemotherapy, dialysis care, wound irrigation, intake/output, blood transfusions, and/or certain ancillary services.

Payments should be made on the basis of per diem costs and providers should not be permitted to keep any of the difference between the case-mix adjusted prospective ceilings and their actual incurred costs. If providers were permitted to keep part of this difference, they would have incentives to reduce quality in this most important area.

Other Patient Care--Items and services not constituting direct nursing care, but still significantly influencing patient care, should be reimbursed in a manner which does not discourage quality. Again, if such services are reimbursed under a flat rate system, incentives will exist to reduce quality by rewarding cuts in an effort to increase profits. Items which should be included in this cost center are religious and social services, activities, dietary and raw food, staff training, medical director expenses, pharmacy, housekeeping, utilities, and plant maintenance.

Arguments might be made that some the items included here might more appropriately be reimbursed with efficiency incentives included. For example, many proprietary homes would generally prefer to have dietary and raw food costs, housekeeping, utilities, and plant maintenance reimbursed under a flat rate system. As a recent survey of 450 nursing home residents by the National Citizens' Coalition for Nursing Home Reform found, environmental factors were determined to be the second most important component of quality care (staffing was first), with food ranked third, activities fourth, and cleanliness sixth. Clearly, food, housekeeping, utilities, and plant maintenance contribute a great deal to the quality of life within a nursing home. The taste and nutritional value of the food eaten by residents are extremely important to their health, happiness, and satisfaction. Too many homes smell of urine and feces, have paint peeling off the walls, poor temperature control, and neglect to promptly change soiled bed sheets. Allowing SNFs to make a profit on these essential components will provide incentives to skimp on these items and residents' quality of life will surely suffer.

Other patient care costs should be reimbursed on a per diem basis for actual costs incurred, limited by facility-specific ceilings. Facility-specific ceilings would take into account characteristics influencing costs in this center which are often beyond the home's control, including different wage levels, square footage, bed size, air conditioning requirements, facility age, and residents' special dietary needs.

Administrative and General Services--These services do not have a substantial effect on the quality of patient care and, therefore, represent the greatest potential for cost containment. They include administration, medical records, operations, capitalized organization and start-up costs. To

motivate efficiency in these areas, reimbursement should be made according to class rates on the basis of median costs for similar facilities.

This is the only cost center in which providers should be permitted to retain a part of the difference between the reimbursement rate and the cost actually incurred. Facility-independent payments based on a percentage of median costs will provide stable, certain rates and will induce cost containment.

Capital Costs--Property costs should be reimbursed by a fair rental value system using a gross rental concept. This arrangement allows the value of assets to increase with market conditions and is advantageous because it permits appreciation of the capital asset in an inflationary economy without requiring sales, refinancing, or leases; provides incentives for owners to seek efficient financing arrangement; and encourages long term ownership which will enhance quality of care.

In response to the reasonable limits placed on asset valuations in Section 2314 of the 1984 Deficit Reduction Act, many states are implementing fair rental value capital reimbursement systems. AAHA fully endorses this new direction and encourages Congress to follow the states' lead by implementing such a system for Medicare.

AAHA strongly believes that nonprofit homes should be permitted a capital maintenance allowance under the property component of the SNF Medicare reimbursement system. While the need for SNF Medicare services increases at a rapid rate, growth in the nonprofit sector has been suffocated by restrictions on surplus accumulation, lack of return on investment, and control on expansion. With limited opportunities to accumulate needed investment for capital replacement and expansion, or the recoupment of costs associated with

present investment opportunities, the nonprofit sector is at a severe disadvantage in continuing to serve the elderly through the Medicare program. Unless nonprofit providers are permitted some form of capital maintenance allowance, an increasing number of nursing home beds will be controlled by conglomerate corporate entities.

In general, AAHA has emphasized, throughout its history, the importance of the social components of care in the delivery of services to the elderly. Broadly defined, the social components are arrangements which allow and encourage older people to fully realize themselves as both individuals with personal dignity and as members of the home's community and the larger community in which the home is located. Several examples of specific social components of care are discussed above in the "other patient care" category. The reimbursement system should recognize and encourage the social components of care so that the quality of life for residents will be enhanced.

Finally, the reimbursement system should encourage quality through linkage with patient care management and outcome measures. HHS should fund demonstration projects to test the research done by Robert Kane of the Rand Corporation on outcome-based reimbursement. Serious consideration should also be given to encouraging quality through rewards based on early discharge of patients to their homes, staffing patterns, inspection, survey and certification processes, and a measure of patient satisfaction.

INTERIM PROPOSALS

Unfortunately, information is not currently available to implement a fair patient-based, case-mix adjusted reimbursement system for the Medicare SNF population. Data on 1,500 patients is now being collected by researchers at the Renssalaer Polytechnic Institute which we hope will be available in some form by this fall. This new data may enable us to move ahead in developing a case-mix payment system which promotes efficiency, access, and quality of care. However, we cannot wait until next year to address the many serious problems articulated here. Congress must act now to ensure that Medicare beneficiaries receive the post-hospital services they need, hospitals are able to discharge patients as soon as it is appropriate, and significant Medicare savings can be realized when DRG rates are rebased. We now must determine what reforms will help meet older Americans' needs for services they have been promised.

Although no formal recommendation was made in the SNF report, HCFA previously raised the possibility of basing the payment system on the percentage of Medicare patients in the facility. AAHA and 21 other members of the Leadership Council on Aging Organizations have expressed strong opposition to such a plan. The Leadership Council noted that such a flat rate system would engender serious harm to the health and well-being of older Americans by providing strong incentives to reduce the quality of care in nursing homes and to deny admission to those in greatest need of skilled care, while shifting spending from patient care to windfall profits. We reiterate our opposition to this overly simplistic notion.

Another interim system would link the SNF Medicare reimbursement rate to each state's Medicaid nursing homes rate. AAHA strongly opposes this

suggestion. SNF Medicare patients are quite different from Medicaid nursing home patients, as documented in the HCFA report and in a March 1984 study conducted by the University of Colorado Center for Health Services Research. The acute care-oriented rehabilitative needs of SNF Medicare patients would not be accounted for in any Medicaid system which has been constructed to pay for treatment of patients having primarily chronic illnesses and custodial care needs. Medicaid reimbursement is already inadequate in most states, paying approximately 15 percent below the actual costs of providing care to Medicaid nursing home patients. Medicaid payments for the more expensive treatment of Medicare patients would be even farther below costs, resulting in losses for virtually every participating provider. Given the same rate of payment, homes would be extremely reluctant to admit a Medicare patient if they were able instead to admit a Medicaid patient with much lighter care needs. Finally, Medicaid rates vary widely across states, therefore, there would be no uniformity in the reimbursement system and facilities and beneficiaries in states with poor Medicaid programs would suffer disproportionately. Tying Medicare reimbursement to the Medicaid rate would be extremely unwise, as providers would have even less incentive than at present to participate in the SNF Medicare program.

Another tentative proposal has been to add some percentage on to the hospital DRG payment in order to permit hospitals to contract for Medicare SNF services. AAHA opposes such a system as it is administratively unfeasable at this time and potentially could be subject to abuse. The hospital DRG is not indicative of SNF Medicare costs, as the HCFA report reveals, explaining only 6 percent or less of the variance in SNF Medicare charges. Since there is no correlation between DRG and SNF Medicare costs, DRGs are not an appropriate

proxy case-mix measure. HCFA would be forced to pay hospitals a flat rate under such a system, resulting in the aforementioned quality and access problems. Clearly, DRGs cannot substitute for a case-mix measure which applies specifically to SNF Medicare patients. Such a system would encourage hospital-based care over free-standing care, unnecessarily increasing SNF Medicare spending because hospital-based facilities are 100 percent more costly than free-standing facilities. The proposal, therefore, would be cost inflating, not cost containing. Finally, hospitals could have incentives to "game" the system by retaining the funds received and/or inaccurately characterizing those pa ents who are eligible for such payments. Clearly, such a system would not only be cost inflating but would also be impossible to implement at this time.

Without question, the only logical prospective system we could adopt immediately is one which pays facilities according to their historical costs, trended forward by an inflation factor. Such a methodology would promote cost containment without providing the kinds of incentives to cream-skim or reduce quality of care, as inherent in the other alternatives. Another advantage of this proposal is that providers are already familiar with working under such a methodology, since thirty states reimburse nursing homes for Medicaid in this manner. The system would account for each facility's patient mix, for differences between hospital-based and free-standing facilities' costs, and for unique structural and geographic characteristics. Facility-specific prospective rates currently are a portion of the DRG system's phase-in process It makes perfect sense to apply a similar system to SNF Medicare providers, while eventually phasing in a new patient-based, case-mix system when it becomes operational. Such a strategy has broad support from both the academic and provider communities.

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In conclusion, senior citizens will soon be facing a crisis of epic proportions unless Congress enacts changes in the SNF Medicare benefit to improve access for patients needing post-hospital care. Presently, the disincentives to participation are staggering. A new system must be developed which addresses these many problems; encourages quality care through patient-based, case-mix adjusted payments; reimburses for actual costs incurred within the constraints of prospective ceilings which promotes efficiency and cost containment; and initiates an interim system using facility-specific reimbursement as soon as possible. Unless such reforms are enacted, thousands of elderly citizens will be tossed out into a vast no-care zone and government spending on health care will significantly increase. AAHA strongly urges Congress to quickly insitute changes as we have suggested so that older Americans will be able to receive the SNF Medicare services they need and have been promised.

STATEMENT OF PAUL WILLGING, PH.D., DEPUTY EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION, WASHINGTON, DC

Dr. WILLGING. Thank you, Mr. Chairman. I am Paul Willging, deputy executive vice president of the American Health Care Association, and I am accompanied by Dr. Robert Deane, vice president for research and planning at the American Health Care Association. The AHCA does represent the vast majority of American nursing homes, and we appreciate the opportunity to testify on this very critical issue, Mr. Chairman. I would have to take strong exception to Dr. Davis' contention that the system is not broken.

The CHAIRMAN. I'm sorry—not what?

Dr. WILLGING. That the system is not broken. We would contend that the system is broken as far as the SNF Medicare benefit is concerned, and we think it has been broken for a number of years. Certainly, the DRG system has exacerbated that problem. Quite frankly, despite what the statute says, despite the Medicare eligibility of a number of America's elderly, they simply do not in many States have a benefit called skilled nursing care. I read the same data that Dr. Davis reads, and I draw quite the contrary conclusions. If indeed we are to say that the problem of access exists only in isolated pockets, I can only assume we are talking about an isolated pocket being an entire State, or perhaps whole groups of States. Indeed, of the skilled nursing facilities in this country, one-third of them do not participate at all in the Medicare program. In 20 States the numbers of beds per eligible population have actually been reduced over the years 1978 to 1982. In a State like Texas with 1,000 facilities, only 29 have chosen to participate in the Medicare program. In a State like Oklahoma or Arkansas, in the entire State, there is only one facility participating in the Medicare program. The system is clearly skewed. Ten percent of skilled nursing

facilities provide 40 percent of the care, and in six States over half the facilities participating in the Medicare program are housed. We have a benefit now which is geared for urban——

The CHAIRMAN. I did not hear that.

Dr. WILLGING. Fifty percent of the facilities providing the Medicare benefit are just in six States, Mr. Chairman. We have a system which is oriented—which is geared—for urban areas, for high-volume, high-cost facilities, and if the Medicare beneficiary is unfortunate to live in rural America, the benefit available in the statute quite frankly is not there. We think that there is a solution to the problem. We do not think that we can afford to wait for the 3 to 4 years before the Health Care Financing Administration comes up with a recommendation, another year for enactment of legislation, and conceivably 2 to 3 years before it can be implemented. We do agree with the Health Care Financing Administration that the system we need is an acuity-based system. The system we need ultimately is a casemix system. We do agree with the Health Care Financing Administration that the data base is today not there. What we are suggesting, however, is that the system currently in place is so inadequate to the needs, the problems are so serious in terms of access that if we don't do something today, we are going to have a benefit which, 5 or 6 years from now, will be limited to very small parts of this country in very high cost facilities. We would suggest that the solution is not exclusively related to the reimbursement system. There are multiple problems which lead to limited access, but core to many of those problems is the reimbursement system—retroactive adjustments, incredibly archaic interpretations of coverage determinations owners' cost reporting, the lack of flexibility inherent in a cost reimbursement system. And the system quite frankly in terms of the level of payment oriented toward the lowest common denominator within the facility, namely the Medicaid patient, recognizing that the Medicare patient has a higher level of need, requires more reimbursement, not the same level of reimbursement. DRG's have exacerbated the problem. The President's proposal to freeze the Medicare SNF rates will further create a problem. As Mr. Glaser suggested, 35 percent of facilities are currently at those limits. In those 6 States with the heaviest concentration of Medicare facilities, up to 65 percent of the facilities are already at that level. We would suggest that a system can be put in place immediately, built on the existing structure, trending forward the existing rates, making them prospective. We would say that as a part of that proposal, we would also make special efforts to deal with the needs of the low volume facility in rural areas. We would suggest that below a certain threshold that the low volume facility not have to go through the cost reporting mechanism but simply be provided the average rate in that region so as to bring in more and more facilities at the low level of participation. We think the system could be implemented immediately. It does not in fact require any change in existing processes or data bases or cost reporting mechanisms. It would deal with the problem of access in the short run. It would be transitional and that it could and indeed would eventually be changed when we get to a casemix reimbursement system, but I think that it would be much better than what we have today. It would go a long

way toward dealing with some of the most basic problems inherent in the existing system while we all work together to develop that ultimate system which will probably take 4 to 5 years. Thank you very much.

The CHAIRMAN. Thank you.

[Dr. Willging's prepared written statement follows:]

STATEMENT OF PAUL WILLGING, PH.D., DEPUTY EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION

Mr. Chairman and Members of the Committee:

I am Paul Willging, Deputy Executive Vice President of the American Health Care Association. AHCA is the largest association of Medicare nursing home providers.

This Committee has acted responsibly in reforming the Medicare payment method for hospitals. You moved hospitals off retrospective, cost reimbursement in 1982 to a target rate program and then in 1983 to a 3 year phase-in of the diagnostic-related group (DRG) prospective payment system. I urge you to begin the logical step of implementing a similar phase-in of a prospective system for Medicare skilled nursing facilities (SNFs).

The evidence is overwhelming that the Medicare SNF system is broken, but it can be fixed. There is an increasing need for action on SNF prospective payment and initial, important changes can be made now to improve the situation for beneficiaries, taxpayers, and providers. The problems of patient access to needed SNF services, already acute in many areas of the country, are worsening because of DRG impacts and an outmoded payment methodology. Even before DRGs were begun for hospitals, we urged action on implementation on a prospective payment system for SNFs. That step is increasingly important as the DRGs are phased-in not only because of the incentives for more patient transfers to SNFs, but because of earlier transfers involving sicker patients.

I would like to highlight the major failings of the present system and then suggest what can be done <u>now</u> so as to lay the groundwork for achieving the benefits of an ideal system.

The major failings can be summarized as the following:

Obstacles to Patient Access to Services

- Low provider participation in Medicare. Less than 1/3 of the nursing homes have even sought Medicare certification. A major reason for provider reluctance is the complexity of Medicare reimbursement. Many providers initially in the program have terminated participation.

- Geographic disparities in Medicare SNF availability:
  - Only 25% of the SNFs are in rural areas.
  - 30% of SNF patient days are concentrated in 2 states, 50% in 6 states.
  - 9% of the SNFs provide fully 40% of patient days and 40% of the SNFs provide only 9% of the patient days.
  - Beds average 18/1000 elderly beneficiaries, ranging from 1 (Arkansas and Oklahoma) to 51 (North Dakota).
  - Patient days average 310/1,000 elderly beneficiaries, ranging from 1 day (Wyoming) to 635 days (Kentucky).

- Increasing demand for SNF beds. This is a direct impact of DRG incentives for hospitals to discharge patients in greater numbers to SNFs.

- Financial disincentives for admission of "heavy care" patients. This longstanding problem is worsening with the DRG incentive for earlier hospital discharges.

Obstacles to Delivery of Services Cost-Effectively

- No incentives for provider efficiency.
- Unnecessary payments, even with DRGs, for patients "backed-up" in hospitals awaiting SNF placement.

To those who suggest that nothing should be done this year about SNF payments, I would remind them that the Administration is suggesting something should be done this year. Unfortunately, their suggestion is the counter-productive step of freezing SNF reimbursement. The possibility of Congressional approval of the Administration's SNF payment freeze, even for one year, will inevitably worsen patient access and undermine DRG success. With such possibilities, we cannot afford to wait until all the research questions are answered.

What we offer is a constructive and cost-effective way to deal with the SNF payment method problems. To those who claim that there are not sufficient data and experience to change, I would say first that there are sufficient data and experience to know that the present method fails everyone. We know enough to begin to move now! A transitional program is an expeditious way to develop the precision and refinements of an ideal system.

If Congress is to exercise its responsibility in establishing nursing home reimbursement policy and introducing concepts of cost containment and improved patient access, it should act now. Considerable experience is available from state Medicaid nursing home reimbursement systems to determine which system features will work and which will not. While Medicaid and Medicare patients are different, we know enough from our Medicaid system to structure an improved and workable interim system for Medicare. Medicare-specific patient data are only now being acquired by HCFA. This transitional prospective system can then be modified as the findings of the ongoing research become available.

Prospective payment has successfully served as the foundation of Medicaid nursing home reimbursement for many years and Medicaid pays for 30 times more nursing home patient days than does Medicare. We share your frustration that the Health Care Financing Administration has ignored the Congressional mandates for recommendations on a prospective payment plan for the much smaller Medicare SNF program.

I can appreciate that members of this Committee may have ideas on how they would structure such a system; we have our ideas as well. While I believe there is general agreement that the ultimate system should relate reimbursement to individual patients' needs, I would agree with the Department that data are not available at this time to adopt the "perfect" plan. The transitional approach recommended by the American Health Care Association maintains the <u>flexibility</u> necessary for Congress to make adjustments without delaying the first steps toward a prospective system. Our transitional approach establishes a very solid base upon which a final system can be built. The Medicare DRG payment for hospitals underscores the need to adopt a transitional prospective system for SNFs now, rather

In brief, AHCA's recommended transitional system features the following:

- Prospective rates covering all operating and most direct patient care expenses. Rates would be based on a facility's reported costs, indexed forward, up to a ceiling fixed by the costs of comparable facilities. The ceiling concept is similar to the existing "Section 223" limits on routine costs.

- Per unit payment for a small number of special ancillary services (e.g., therapies) with high cost and highly variable utilization. Currently, certain services are separately paid.

- Efficiency incentive payments for keeping costs below the ceiling. A facility would receive a proportion of the difference between the ceiling and its prospective rate, limited to a percentage of the ceiling.

- The prospective rate and ceiling computations would include actual capital costs paid plus a simple percentage add-on for growth and return on investment.

- For the many facilities with low Medicare volume, rates would be set at the ceiling, rather than reported costs.

- Simplified cost reports for those above a Medicare volume threshold and the burden of cost reports eliminated for low volume facilities.

A more full description of the transitional system recommended by the American Health Care Association and the steps necessary to arrive at a final system are presented in the Appendix. The present discussion, however, will concentrate on several of the more important outcomes that can be expected from expeditious Congressional action on a transitional approach.

More cost-effective services and the opportunity for serving more Medicare patients at current expenditure levels would be achieved by the introduction of fixed rate payments and provider efficiency incentives. This clearly has been the reason for the success of the hospital DRG payment method. The current retrospective, cost-based reimbursement system contains few incentives to restrain costs, since providers are reimbursed for their actual expenditures up to the cost limits. In other words, the current method provides no financial reward for efficiency in controlling cost since reductions in cost result in corresponding reductions in payments.

We recommend an incentive approach that provides a continuing reward for efficient operations which is proportional to the degree of efficiency achieved and allows the facility to respond to the impacts of DRGs. This incentive would allow facilities to keep some portion of the difference between their prospective rates and the ceiling. These incentive payments would support expected increases in the intensity of services which would be expected in the short-run with admissions of heavier care patients. The incentives, however, are limited to discourage cost reductions which would result in an adverse impact on quality of care.

Improved access for "heavy care" patients would be achieved during the transition by the separate payment of certain ancillary services. This is a critical area for refinement in progressing to a final system and of increasing importance because of the DRG incentives. Medicare reimbursement provides no incentives for admitting patients with heavy care needs. Its cost averaging method does not differentiate for the higher costs associated with providing care to patients with greater than average service needs. Unfortunately, heavy care patients often remains backed-up in the hospital at a substantial cost to Medicare, even under DRGs. Until better case-mix measures and data are available, at least the higher costs of special services should be recognized and providers allowed the flexibility, by means of incentive payments, to increase staffing, etc. to meet the more costly needs of these patients.

Maintenance of quality care would be assured by the continued separate payment of certain ancilliary services and the limitation on provider incentive payments.

Until better case-mix measures and data are developed, it is important to identify a select number of services and therapies, which are fairly standardized and directly related to patient care, and pay for these services as they are utilized. Thus, the provider has no incentive to withhold or otherwise reduce the utilization of the service by the patient. With professional review of service appropriateness, this feature will go far in maintaining quality care under conditions of efficiency.

A reimbursement system can ensure that resources are available for quality care; it cannot ensure quality care. On the other hand, the reimbursement system can be designed to minimize the conflict between providing quality care and generating excess revenues.

The most obvious way is to limit the incentive payments so that "cost containment" below a certain level no longer generates incentive payments. We propose incentive payments be limited to a percentage of the ceiling. A more effective way of resolving the dilemma, which is suggested for the "final" system, is to separate-out those costs which are for direct patient care from consideration for efficiency incentives payments and to pay these costs by prospective patient-based rates.

Improved patient access, even more critical because of DRGs, will be achieved by making Medicare participation more attractive for SNFs, leading to an increase in the beds available for Medicare SNF patients. In the long run an adequate bed supply will develop because returns on investments in nursing homes will be competitive with other investments.

AHCA's transitional program would achieve major gains in the number of Medicare-certified beds by greatly reducing barriers to participation for the many facilities which only have small numbers of Medicare patients. For instance, 1400 of the participating SNFs have less than 1000 patient days per year. A threshold of Medicare volume would be set, below which a SNF would be offered the prospective ceiling as its rate. Once the threshold utilization level is reached, the facility's prospective rate would be based on its own reported costs. In addition, providers with less than the threshold Medicare utilization level would not be required to file the Medicare cost report.

Lastly, an attempt must be made to reduce Medicare's unnecessary involvement in the administrative details of nursing home operations by reducing paperwork burdens, federal reporting, regulations, and accounting requirements. Already mentioned is the elimination of cost reports for those facilities below the participation threshold, but cost reports can be greatly simplified for those above the threshold as well.

In conclusion, I cannot but note the irony of our consideration today of issues relating to access to nursing home beds, quality care and provider reimbursement under Medicare -- a program which affects only three percent of the patient population in nursing homes -- when next week you will be asked to consider a freeze on Medicaid -- which impacts on over 60 percent of the patients in nursing homes -- and its conversion from an entitlement to a block grant program. The immediate impact on services and quality care of the Medicaid cap will be severe; its impact, as the elderly population expands, will be devastating. It's not simply a matter of dollars or fairness, its whether the medically poor will be able to receive benefits to which they are now entitled. Furthermore, a block grant program that also calls for elimination of federal minimum reimbursement standards is certain to have an effect on the quality of the services as states reduce payment rates and providers are forced to reduce the number or level of services.

AMERICAN HEALTH CARE ASSOCIATION

Medicare SNF Reimbursement:

Transitional Proposal

Three primary goals are to be achieved by a change in the SNF Medicare reimbursement methodology. The first is to improve patient access to care, particularly "heavy care" patients. The second, but related, goal is to increase the participation level of long term providers in the Medicare program. The third goal is to provide a potential for significant cost containment in the long-run. All of these goals are intended to bring SNF reimbursement principles in line with the new hospital PPS and to anticipate and accommodate the consequences of PPS for skilled nursing facilities.

Short-Run

It is felt that for the short-run, a facility-based prospective system could be implemented almost immediately that would represent a significant step toward meeting these three primary goals. Prospective rates would be established annually on the basis of reported costs (indexed forward) of each facility. These prospective rates would be subject to a ceiling based on the median of reported costs in the geographic region (possibly, the current regions used for establishing Section 223 limits) plus a percentage as yet to be determined, but of about 10-15 percent. A median plus a percentage is suggested so that prospective rates will be limited by a reasonable, stable ceiling that would permit all efficiently operated facilities to have their costs reimbursed.

For facilities beneath some threshold level of participation in the Medicare program (e.g., 3,000 to 4,000 annual Medicare patient days), a prospective rate would be determined in each geographic region as a percentage of the geographic median rather than from the reported costs of each facility. These prospective flat rates should be set high enough (90 to 100 percent of the geographic ceiling) to provide an incentive for facilities to enter the Medicare program, increase their levels of participation, and rise above the threshold level of participation so that facility-specific rates can be established from their own costs. Facilities below the threshold would not have to submit Medicare cost reports at all, while the cost reports for those above the threshold level should be greatly simplified. The complexity of the cost report would be a function of the degree of specificity desired for the cost indexing process when setting facility-specific prospective rates.

In order to introduce continuing cost containment, an incentive payment should be made to all facilities above the threshold level of participation that is proportional to the difference between the prospective rate and the geographic ceiling. The size of the proportion must still be determined, but should be around 0.5 so that it is large enough to be meaningful to the provider and yet small enough to allow the government (the taxpayer) to share meaningfully in the efficiencies introduced. Total incentive payments should also be limited to some percentage of the ceiling (e.g., 10 percent) in order to prevent draconian cost containment which may negatively affect patient care.

A great deal of care must be exercised in the establishment of the prospective rate geographic ceilings, the threshold level of participation for geographic prospective payment, and the geographic prospective payment rate for those beneath the threshold. If current budgetary considerations become overriding so that these system parameters are set too low, the entire system design will have been frustrated and none of the three goals of improved patient access, increased provider participation, and long-run cost containment will be met.

The capital costs for each facility should initially be folded into its prospective rate and included in the computation of the ceiling for all the facilities in the geographic area, and the rate of return on equity replaced with a small fixed percentage add-on (e.g., 6 percent) to the sum of the other facility-specific capital costs (i.e., depreciation, interest, insurance, and taxes). In other words, a facility's capital costs plus 6 percent will be included in its prospective rate. This procedure will avoid the complexity of the equity computation and provide for equitable treatment of all facilities regardless of ownership. Since Medicare is such a small part of the total market, this procedure should not impact negatively on the debt/equity decisions of investors.

The only cost elements not to be covered by the prospective rate described above are ancillary costs (i.e., therapies, drugs, x-ray, and laboratory). These expenditure items are costly and highly variable as the patient-mix of the facility changes and cannot be adequately anticipated by a prospective flat rate. Therefore, these expenditure items should be reimbursed in a manner similar to that currently being used under Medicare Part B and should not be included in the computation of the ceilings, the below-threshold prospective flat rates, or the facility-specific prospective rates for those above the participation threshold.

Long-Run

For the long-run, the short-run system could be modified in stages to produce a final system. These modifications are:

1. Introduce patient acuity into the reimbursement for those facilities above the participation threshold by converting part of the operating costs (namely, all nursing service costs plus raw food, activities, nursing supplies, and social/religious services) to a cost-based, patient-related prospective payment system on the order of that currently being developed for Minnesota. Under this system, patient classes are assigned weights in each geographic region based on the values of the resources required in their care. The values of these weights are then established on a facility-by-facility basis from base year cost reports and indexed forward each year between base years. Patients are classified each month as part of the invoicing process and the facilities are paid accordingly. Verification of the invoices can be handled on a sample basis by the intermediary. Research is now underway by HCFA to establish the appropriate set of patient classes so that implementation may begin as soon as this research is completed.

2. Introduce a fair value rental system for capital costs using a gross rental concept. A rental paid on the current value of the total assets (land, building, fixed equipment, and moveable equipment) is paid in lieu of all property costs (return on equity, depreciation, interest, insurance, and taxes). The rental rate should be based on historical money rates of return plus a risk premium, but should also consider the potential profit in the form of incentive payments from operating efficiencies. This element of the long-run system could be implemented as soon as agreement is reached on how the current value of the total asset is to be established.

3. In order to reinforce the incentive to provide access for heavy care patients, it may be necessary to retain the provision to pay for some or all of the ancillaries in a manner similar to that currently used in the Part B program.

The CHAIRMAN. Mr. Glaser, do you want to comment on Dr. Davis' statement that Medicare access is a sporadic problem, and not widespread?

Mr. GLASER. I don't share that same view. I am not sure how current her data is. Under the DRG system, from word of mouth, from what I hear from my colleagues across the country, there is indeed an access problem. People are not—Medicare-eligible patients are not getting into skilled nursing facilities.

The CHAIRMAN. Now, you say because of DRG. Is that because people are being discharged quicker and you are being hit with a glut of sicker patients that you had not projected before DRG and are not prepared to handle?

Mr. GLASER. At the typical facility across the country, yes, sir.

Senator DURENBERGER. Are you going to be able to prove that? The word "glut"?

The CHAIRMAN. I used that word.

Senator DURENBERGER. I know. He agreed with you. [Laughter.]

The CHAIRMAN. All right then. I will change the word: a great many—a lot more than you expected because of the DRG system are suddenly being discharged. In your judgment, perhaps, they would have been better served to have stayed another day or two or three in the hospital, but are being discharged and you are being asked to take them and are not prepared to?

Mr. GLASER. That is correct, sir.

Mr. BEDLIN. Senator, if I might state, there are three studies that have documented the greater pressure that nursing homes are under to admit sicker DRG patients. Even prior to the DRG system, I think that the statistics show a vast undersupply of beds. Total days covered have dropped by over 50 percent between 1969 and 1977. Total days covered per 1,000 beneficiaries have dropped by 21 percent between 1976 and 1982. If you also look at various States that don't have facilities that are oriented toward Medicare you will find that 42 States have fewer than 10 nursing homes with an average census of less than 16 Medicare patients. Thirty States have less than five such Medicare oriented facilities, and 12 States have none of them. So, I think that I agree that Dr. Davis is understating the serious access problem that has existed and is only getting worse.

The CHAIRMAN. Mr. Glaser, why not start moving toward a national rate as we have with the prospective payment systems for hospitals?

Mr. GLASER. I would like to put you into the head of an administrator in a hypothetical facility as an example, and I think that will answer that question, or if not, we will at least have a healthy exchange at the end. May I do that?

The CHAIRMAN. Yes.

Mr. GLASER. Whether this administrator is working for a voluntary facility that has to have a balanced budget for his board of directors or working in a proprietary facility where they may have to show some profit for investors, the typical skilled nursing facility with the kind of patients that we care for under Medicare may be diabetic patients, may be cardiac patients, stroke patients, fractured hip patients, amputees, or dementia patients with aggregate services requiring Medicare services. Now, let's assume that for in-

tensity of care purposes at the low end, that the diabetic patient may cost $50 a day, and on the high end the stroke patient may cost $100 a day. Let's give HCFA the benefit of the doubt and assume that they will give more thought into a national rate system than they have under the 223 limits, and they come up with a rate of, let's say, $70 a day. That administrator is going to look at his patient population when he has two admissions—let's say a diabetic and a stroke patient—and he is going to look at this patient population, or she will look at her patient population, and say, gee, I have so many $100 a day patients—$80, $90 a day patients—I can't afford to take in that heavy-care stroke patient. I had better take in that diabetic patient for $50 a day at cost, and I will make some money. Then, this administrator is going to wake up and realize that he can be a hero for his board or for his investors and say: I don't have to take in any heavy-care patients. I can start making some money if I admit low-care or light-care patients at $50 or $60 a day and being reimbursed at $70 a day. So, I think the system would be gamed and will not be an advantage to the beneficiaries who need services from hospital levels.

The CHAIRMAN. Do you think that the prospective payment and the DRG system is working for hospitals?

Mr. GLASER. Oh, clearly, it is working for hospitals, but I just don't think that it is——

The CHAIRMAN. And working for the benefit of the country?

Mr. GLASER. To the country, financially. To the patients, I have some question in my own mind whether the patients—the elderly patients who are being discharged under the DRG system—are receiving the post-acute care services that they really need, whether it be at the SNF level or the home care level, I have some question. I can't back it up, but it is a feeling that these people are being discharged into no-care zones.

The CHAIRMAN. And you have the same misgiving that this situation would result from any prospective system where we said to you, to the hospitals, or anybody else: You will get *x* amount of dollars per patient. Do you think that has to lead inevitably to a decline in the quality of care?

Mr. GLASER. Under a national rate. Prospective rates, I think, have some promise if it deals with casemix variations.

The CHAIRMAN. Senator Durenberger?

Senator DURENBERGER. I wonder if both of you can reply to the question which is the second half of the Chairman's first question, or at least your reply to the Chairman's first question. If half or something close to half of the Medicare SNF work is being done in six States, what is happening to the folks in the other States? What happens in Oklahoma and Arkansas where there aren't any SNF facilities?

Dr. WILLGING. I think a number of things are happening, Senator. One of the interesting pieces of the HCFA report was the data with respect to back-up days in hospitals. They provided a fairly precise range of 1 million to 7.2 million Medicare patient days paid for in the hospital setting because the placement was not possible as far as the skilled nursing facility bed is concerned. I do agree with Dr. Davis that that is not always waiting for a Medicare SNF bed. Many of these patients would not meet the coverage defini-

tions and would be more likely to end up on the Medicaid rolls, but I think we do have a serious hospital back-up problem, and indeed the dollars accounted for by that hospital back-up problem have been built into the DRG. So, there is a lot of care being provided in the acute care setting paid for through the acute care reimbursement mechanism for patients who more appropriately belong in a SNF. I am sure that many of them are being transported large distances so as to be able to get into one of those facilities that do participate. I suspect that many of them are also quite frankly being discharged prematurely to the home setting where what they really need is an additional 7, 8, or 9 days of skilled care.

Senator DURENBERGER. Is part of it possible—and I want Mr. Glaser's reponse, too—because of the regional variations in the cost of hospitalization? Is it possible that in your high cost hospitalization areas, there are more SNF facilities because there is more incentive to move people to a less expensive treatment mode. Whereas, Oklahoma, Arkansas, the South generally, where hospitalization per diem is fairly low, maybe they can keep the patients in the hospital longer. Is that any factor in this?

Mr. GLASER. You put your finger on it, Senator. Pre-DRG's, hospitals kept patients in their beds for longer periods of time so that by the time they were discharged to the skilled nursing facility level, they were not eligible for Medicare benefits at all. That was a terrible problem faced by nursing homes—admitting people, expecting them to be covered by Medicare, and finding out that they are not indeed. So, I think that matters whether it is Oklahoma or New York or Pennsylvania or wherever. Pre-DRG—I considered that a major problem, even in New York where I am a high volume user. Under today's system, I just don't think the providers have seen the full impact of the DRG system as yet.

Senator DURENBERGER. And the closer we get then to national averaging, the more we are rewarding the low cost States, which are largely in the South and some other areas. And in these areas, for one good reason or another, they have kept the costs down, making it more difficult in the high cost States to use the hospital as a means of providing certain set of services. So, we are increasing the need for nursing home, or skilled nursing, alternatives in one part of the country and not increasing the need in another part. Is that part of the problem we are talking about?

Mr. GLASER. I think so, and complicating the problem even further, hospitals are discharging these people into rehab hospitals or rehab units that are exempt from the DRG's and are still at a very high cost per day service level.

Senator DURENBERGER. Thank you.

The CHAIRMAN. Senator Baucus.

Senator BAUCUS. Gentlemen, why would Dr. Davis read the data differently than you do? I know different people have different points of view, and it all depends upon the eyes of the beholder, but you all seem to be saying that it is so glaringly different from what she represented that it is not really a question of interpretation. Why would she be reading it differently than you do?

Dr. WILLGING. Senator, I guess I could speak from the perspective of one who used to represent the executive branch often at this table, and I can tell you why I would have read the data different-

ly. If the executive branch were to read the data as I and Mr. Glaser read it, it would imply as we have implied, that we have a critical problem that requires a solution now—not a solution 3 or 4 or 5 years from now but today.

Senator BAUCUS. But why did she not read it that way? Why did she say let's get better data and wait several years? It is somewhat of a problem but it is not enough of a problem to do anything for 3 or 4 years. Why did she say that?

Dr. WILLGING. Look at the program from the perspective of the Health Care Financing Administration—$100 billion budget, the vast proportion of which is hospital. Serious problems in terms of growth rates and home care. Now, this is a small potatoes program from the perspective of the Health Care Financing Administration. It is a program that has not essentially grown. In fact, per diem rates to nursing homes of the last 10 years in real dollars have actually declined .3 percent per year. It is not a program that consumes a lot of energy on the part of the Health Care Financing Administration, and I can understand that. It is 1 percent of the Medicare budget. They have lots of fish to fry and from their perspective fish that are much more critical than this one. From our perspective, I guess, as well one could say, well, why do we care? I mean, Medicare is only 2 percent of nursing home revenues. This industry can quite frankly survive without the Medicare program. As one-third of the skilled nursing facilities have shown, they choose not even to participate in the Medicare Program.

Senator BAUCUS. Then why do you care?

Dr. WILLGING. We care because there is an access problem, and quite frankly in this industry, when there is an access problem, the finger pointing is often to the industry itself. Somehow we discriminate against Medicare patients. We won't take them, and the problem warrants resolution because the beneficiaries have an entitlement to that benefit, and it is, I think, to our interest to see that they do get that benefit.

Senator BAUCUS. Why wouldn't the same reasoning be valid for HCFA then? Even though it is small potatoes and it is small potatoes for you, if there is an access problem and the finger is pointed at you, why wouldn't that same reasoning apply to HCFA?

Dr. WILLGING. I suspect it would, but once again, there are 24 hours in a day. They have an incredible number of issues they have to deal with, and I think one does have to set priorities. They have not set this at as high a level as we would.

Senator BAUCUS. Do you think that the best argument you can give us is that HCFA should set this at a higher priority now as compared with other fish that it has to fry?

Dr. WILLGING. The argument that I would give, Senator, is that in putting the DRG system in place, Congress fixed half the equation, provided incredible incentives to hospitals to discharge patients quicker and sicker, provided no incentives whatsoever to the other half of the equation so that skilled nursing facilities would accept those patients. I think what Congress should do is look at the system in terms of its totality, that both sides of the equation should be in sync, in balance, and in doing so, the DRG system itself in the hospital sector will work better. One will be able to

pull down those back-up days and back-up dollars being paid for within the hospital sector.

Senator BAUCUS. But what other fish in particular are now frying that you think they should not fry?

Dr. WILLGING. I probably won't respond to that one, Senator. [Laughter.]

Senator BAUCUS. I am asking you if you can just give us some clues. I mean, logically, you are putting us in a box. You say that there are 24 hours in a day and they only have a certain number of fish to fry and you are small potatoes. I think the logical extension of that is: We shouldn't put a lot of pressure on them. So, I am asking you where should HCFA spend a little less time perhaps?

Dr. WILLGING. I think what I am suggesting, Senator, is that HCFA is, in terms of the ultimate system, doing what it should be doing. The casemix reimbursement system we all want, which makes sense, which has to be put in place, will take analysis, will take more data, will take more research—they are doing that. What we are suggesting is the transitional system which would not require a great burden as far as HCFA is concerned. We have designed it so that it is based on the existing processes, would require no more intermediary efforts, no more analytic effort, would deal with a good number of the problems—not all of them but enough of them to make this benefit more widely available. And that is, I think, something that would allow HCFA to deal with the issue without having to expend great amounts of new resources. Since I don't want to suggest that anything they are doing they shouldn't be doing, I would like to suggest that they can do something that won't force them to make choices.

Senator BAUCUS. Thank you.

The CHAIRMAN. Senator Long.

Senator LONG. I was just looking at a chart here that indicates that Louisiana has nine of these facilities, which works out to about one in every congressional district, if you want to just average them out so they were evenly distributed. And I asked my staff assistant here why there are so few, and he said that Louisiana has more than 9 facilities, but they are not satisfied with the reimbursement that they get under Medicare and therefore they prefer not to participate. Does that make sense to you, Dr. Willging?

Dr. WILLGING. That makes a lot of sense, Senator. The way the system works, and it perhaps works well for hospitals—the cost reimbursement system—in the sense only that Medicare patients make up such a large proportion of hospital patients. But in the skilled nursing facility, the average number of Medicare patients among 100 is about two. So, what happens is the cost reimbursement systems averages the cost for all patients, and then pays for the Medicare patient based on that average. So, as Mr. Glaser suggested, the system almost guarantees that for every Medicare patient who comes in the door, the facility loses money. Is that a fair statement, Mr. Glaser?

Mr. GLASER. Absolutely.

Dr. WILLGING. And altruistic as we can be in the nursing industry, bankruptcy is not an alternative we look forward to. And so, it is best not to accept that Medicare patient, not to participate in the program if it is a guaranteed loss.

Senator LONG. Now, let me get that straightened out. Are you saying that under the program you have right now each time you accept a Medicare patient, you tend to be taking a loser?

Dr. WILLGING. For those facilities that do not have a high enough volume—that they have distinct parts or are primarily Medicare—yes, you lose money.

Mr. GLASER. I have volume, Senator, and I am losing $25 a day for every Medicare patient, and I have 28,000 Medicare days a year. Since the beginning of the 223 limits, I have lost over $3 million since 1980 because of the 223 limits. And I have been trying to appeal through the HCFA process to try and obtain relief, and I now have to go before the PRRB and probably take HCFA to litigation, just in order to serve patients.

Senator LONG. I am one who would be sympathetic to your problem then because you may recall that I was the one who insisted they put an amendment on one of those bills some years ago to say that we will pay a reimbursement rate that would permit the hospitals under Medicare and Medicaid to make about the same kind of income as the average for manufacturing. It just seemed to me that we ought to be in a position to attract capital on a competitive basis with others out there in the economy if we wanted the facilities built. And so, that was my amendment. Now, some thought that would cost us some money. My feeling was that if you want the hospitals and the nursing facilities, you ought to do that. I see you are nodding. That makes sense—just so they can compete for capital. I mean, basically, how are you going to build private hospitals and nursing homes if you can't compete for the capital to build them with? If you have a need for a facility somewhere, someone has to pay to get one built. Now, I would think that this nursing home shortage must be costing us money, that the people are trying to stay in the hospitals because, if they leave the hospital, they will not have nursing home care available. The Medicare program was intended to make it possible for these kinds of patients to be moved into a skilled nursing facility for a few days until it was safe to discharge them. I should think we might save money by spending a little more to make additional skilled nursing facilities available to Medicare patients so that they could be moved into them rather than keeping them in the hospitals.

Dr. WILLGING. Certainly we would accept that argument. This concept of budget neutrality is a funny animal floating around town the last few years. If you look at the SNF benefit in terms of budget neutrality and say that you don't want to spend one more dollar for SNF care, that is one way of looking at budget neutrality. But if you look at the total Medicare system on the part A side and recognize that there are dollars being spent on the hospital side because of back-up problems and look at budget neutrality within that broader concept, then you are right, Senator. One can actually save money by using the lower cost alternative.

Senator LONG. If you had somebody at home who was reasonably well qualified and knows something about looking after sick people, that is one thing. But if you don't have that competence at the home, then to discharge a patient who still needs some very close care is really a disservice, I would think. It is failing to look after the citizen the way you should. Now, I was for the DRG system. I

thought it would help to get people discharged and make the hospitals more efficient, but it seems to me that when we are economizing on these skilled nursing facilities here, we might be making a grave mistake, both with regard to the beneficiary and the tax paying public. And also just in terms of cost, I think that any doctor who has any human kindness in him would be reluctant to discharge a patient as early as he could if the patient needed skilled nursing home care and the doctor knew that there was none available out there.

Mr. GLASER. I applaud your insight, Senator. You are right on target.

Senator LONG. I guess you agree with that, too, don't you, Dr. Willging?

Dr. WILLGING. I think there is a cliche, Senator: pennywise, pound-foolish. And I think that is what we see with respect to this configuration of the two benefits—the hospital and the nursing home benefit.

Senator LONG. Could I explore just one other item, Mr. Chairman, for a moment? Dr. Glaser——

Mr. GLASER. Mr. Glaser.

Senator LONG. Mr. Glaser made available to us this worksheet that you have to work from: "Institutional Costs for Skilled Nursing Facilities and Health Care Complexes." I have just glanced over it, and I would gain the impression, Dr. Willging, that the purpose here is to try to have a uniformity of bookkeeping so that, when the Government goes to audit these things that they would all be completed on the basis of the same, uniform accounting procedures. Does that account for much of what is here?

Dr. WILLGING. That accounts for some of it. I think that if the Federal and State Governments are involved in paying for a service, they have a right to reasonable amounts of data to assure that their fiduciary responsibilities are being handled well. I would suggest as one looks through that cost report, however, one finds that it goes well beyond what the Federal Government needs in terms of its fiduciary responsibility. I find it intriguing when going through a nursing home cost report, some of the things that administrators like Mr. Glaser have to do, such as allocating the costs from one's nursery. Most nursing homes don't have nurseries, yet it is there because essentially what HCFA did is it took the hospital cost report and with very nonsignificant alterations applied it to nursing homes. It talks about allocating the costs from one's gift shop to the Medicare program. Most nursing homes don't have gift shops. That report could probably—and under our system, we would propose—be reduced to about one-third of its present level, still allow the Health Care Financing Administration the data it needs. Most of that stuff is piled on desks and in bookshelves in the Government. It is never used for anything.

Senator LONG. Might I suggest to our chairman here that you, Mr. Chairman, take the lead in seeing that our staff work with these people and also with the Administration to see if this thing can't be shortened to maybe about one-third of what it is. It looks to me as though you would save the Government a lot of money. Do you want to save the Government some money? There is a good chance right there.

The CHAIRMAN. You know, that is intriguing. This is the first time we have ever had a complaint about the length of these forms. [Laughter.]

Senator LONG. I can recall when I was on the Small Business Committee—and that has been many years ago—when the staff didn't have anything else to do—which was most of the time—[Laughter.] They would be working on this voluminous annual report, and it would be voluminous whether there was a great deal to report or not—the size of the report was supposed to justify the size of the committee staff. And I thought it my duty to read through that thing when I got to be a regular member. I think I was probably the only member of the committee who did. I thought it was an outrage to make the taxpayer pay for all that. So, I took just one person out of my own office staff, and we sat there and we rewrote this fool thing and got it down to where it was about one-quarter of its former size. And then I had to reach a compromise with the committee chairman because he thought that reducing the report to one-quarter its size might lead to a reduction in staff.

The CHAIRMAN. Let the record show that that was the Small Business Committee staff. [Laughter.]

Senator LONG. It was. This staff doesn't do that, Mr. Chairman. This staff doesn't have to make work.

The CHAIRMAN. This committee doesn't issue annual reports. [Laughter.]

Senator LONG. That is right.

The CHAIRMAN. We cut it to nothing.

Senator LONG. This is the kind of thing, Mr. Chairman, that is costing the Government a ton of money—unnecessary bookkeeping and all sorts of unnecessary reports to fill out. Perhaps we should the people responsible for all this paperwork put the costs in their budgets—because in the last analysis the taxpayer is paying for all these reports. That is all I have.

The CHAIRMAN. Let me ask you both this question. I take it you think the present system is so bad and the reimbursement system is so poor that you are prepared to proceed regardless of HCFA. We should forget the report and not worry about any further studies on prospective payment for hospitals—they probably wouldn't work for nursing homes. Some change must be made, however. Do I read you right, Mr. Glaser?

Mr. GLASER. Absolutely, Senator. I think it is important and it is a way of providing more access. The current system is not working. We are suggesting an interim step until clearer investigation is conducted and completed, and we may unclog the backlog a little bit.

Dr. WILLGING. The industry is in agreement on that.

The CHAIRMAN. Let me come back to you, Mr. Glaser, in terms of Medicaid. You say that Medicaid reimbursement is 15 percent lower than the costs for Medicaid patients.

Mr. GLASER. Yes, sir.

The CHAIRMAN. And nearly half of all nursing home reimbursement comes from Medicaid.

Mr. GLASER. Correct.

The CHAIRMAN. How do the large majority of nursing homes manage to stay in business, given that situation?

Mr. GLASER. I can only speak for the voluntary sector. Fortunately, I have a board of trustees that raises money and we are able to survive. The Medicaid patient—it is an average cost—is a less intensive level of care than the Medicare patient.

The CHAIRMAN. But you lose money on them anyway?

Mr. GLASER. We lose money. I happen to have a little bit more favorable reimbursement, but I am losing approximately 5 percent on every Medicaid patient I have.

The CHAIRMAN. So, you are making it up out of charitable contributions?

Mr. GLASER. Correct, sir.

The CHAIRMAN. Now, Dr. Willging, how are you doing it?

Dr. WILLGING. It is a serious problem in the industry, and unfortunately, it is a problem which has led the industry to be accused of having to discriminate against Medicaid patients.

The CHAIRMAN. Would the average of 15 percent be average for your homes?

Dr. WILLGING. It depends upon my homes—the ones I represent are across the entire country—in 50 States. It depends upon the States. There are some States that do adhere to the provisions in the statute which say that the reimbursement under Medicaid should be sufficient to cover the costs of the efficiently managed home. In other States, quite frankly, the States are not coming close. There are States which pay in the low $30's—$31, $32 a day—for a 24-hour skilled nursing day, three meals, recreation. We won't go into hotel rooms at $30 a day much less a nursing home.

The CHAIRMAN. But where are you making it up? Mr. Glaser is making it up on charitable contributions.

Dr. WILLGING. The way we are making it up in most facilities is that they have to balance the census between the Medicaid patient and the private pay patient. The private pay patients are charged more than the Medicaid rate. That is the only way facilities with a heavy Medicaid volume can in effect maintain their financial stability.

The CHAIRMAN. Apparently, on the average you can't pick it up out of Medicaid anyway. You don't have enough of a Medicare load proportionate to your total population.

Dr. WILLGING. So, we have to make it up out of the private pay patient. That is the only way to maintain fiscal solvency.

Mr. BEDLIN. Senator, may I just add that the problem that is created when one is forced to increase charges to private pay patients—what happens is these patients spend down their income at a much quicker rate because they are paying more into facilities, and therefore they become eligible for Medicaid much sooner than they should. So, in the end, I think it does cost the Government more.

The CHAIRMAN. Senator Baucus.

Senator BAUCUS. No more questions. Thank you.

The CHAIRMAN. Senator Long.

Senator LONG. No, Mr. Chairman.

The CHAIRMAN. Senator Chafee.

Senator CHAFEE. No. No questions.

The CHAIRMAN. Thank you very much.

Dr. WILLGING. Thank you, Mr. Chairman.

Mr. GLASER. Thank you, sir.

The CHAIRMAN. I am going to switch the next two witnesses. Ms. Jones has to catch a plane at 11:50, so I am going to ask her to testify now. Ms. Clarice Jones represents the American Association of Retired Persons.

STATEMENT OF CLARICE JONES, CHAIRMAN, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS, WASHINGTON, DC

Ms. JONES. Thank you, Mr. Chairman. My name is Clarice Jones, and I am from Lansing, MI. I serve as the chairman of the national board of directors of the American Association of Retired Persons. I am grateful for this opportunity to state the American Association of Retired Persons' views concerning the development of a prospective payment system for skilled nursing facilities participating in the Medicare Program. The association is indeed pleased to set forth our views on the kinds of issues that must be considered as Congress moves toward establishing a prospective payment system for SNF's. My testimony this morning will outline the issues AARP believes make a difference in the efficacy of a prospective payment system for SNF's to assure appropriate high quality care, as well as contain nursing home costs. The development of a prospective payment system for SNF's is desirable for several reasons. The current Medicare SNF benefit is not reliable because of a wide variation in coverage decisions. It makes good policy sense to treat all Part A services on a consistent basis to avoid unbundling of services and to prevent perverse payment and level of care decisions. DRG's are pushing Medicare patients out of hospitals sooner and sicker. A stronger Medicare SNF benefit is necessary to help meet the increased demand for skilled nursing services created by the DRG's. In contrast to the acute care setting, there are tremendous gaps in the data available on nursing homes and nursing home residents. Policymakers need more information and analysis before a stable and reliable prospective system for SNF's can be constructed and implemented. AARP favors the combination flat rate and casemix approach to establish the basis of the prospective payment. Failure to relate payment to the resource needs of the patient will result in skimming and foreclosure access in nursing home care for heavy care patients. In other words, the light load is taken first and preferably. Diagnosis alone is not a sufficient indicator of resource use to be a reliable variable for measuring casemix differences. The casemix system must be grounded on realistic verifiable evaluations of residence care needs, including behavior and psychosocial quality of life factors as well as nursing care needs. Payment should be at a level sufficient to provide good care. Capital costs must be under the prospective payment system. The objectives of capital payment policy should be to assure an adequate supply of quality SNF nursing home beds over time and to maintain as much as possible a continuity of nursing home ownership over time. We went through that sale business before. An adequate certification of need criteria including a better understanding of the balance between institutional care and community and home based care must be developed to guide the construction of additional nursing home

beds. And I am a fan of continuity of care, long-term care needs including respite care, adult day care and assistance to people to keep them in their own homes. So, when I talk about community needs, I am thinking about that also. Even the very best payment system cannot do all that is necessary to assure consistent, accessible quality nursing home care. A strong regulatory system is essential to assure that nursing home residents receive the care they need. There must be a strong link between the SNF payment system and nursing home standards of care, licensing, and regulatory enforcement. I served on a complaint committee for nursing homes in Michigan, and I am very strong for the supervision of the nursing home and the care it gives. Medicare's change from a cost-based system of payment to a prospective system of payment dramatically alters the potential liability of Medicare beneficiaries. Under a prospective payment system, beneficiaries face new financial liabilities and access to care issues that were not present under the cost-based reimbursement system. The Medicare appeals procedures must be improved to adequately check and balance the prospective payment system. Thank you, Mr. Chairman.

The CHAIRMAN. You are prepared to move to a prospective payment system even though there is no serious conclusion yet as to how well it is working in hospitals, other than it is cutting costs for us a bit? You are ready to go ahead and try it anyway for nursing homes?

Ms. JONES. I think we can do that if we utilize the regulatory enforcement and the supervisory tactics that are necessary in any case.

The CHAIRMAN. You lost me there on that answer. What do you mean?

Ms. JONES. I mean that we cannot use the prospective payment system as a substitute for regulation and enforcement and supervision.

The CHAIRMAN. All right. I guess what you are saying, then, is that they can't discharge people too early or they have got to fill some kind of an obligation?

Ms. JONES. Yes.

The CHAIRMAN. Now, you talked about certificate of need. What changes do you want to make in the present certificate of need program?

Ms. JONES. I would like to strengthen the enforcement of the certificate of need, and that has varied so much in so many places or has not been applied or has been worked around so that they didn't follow the recommendations.

The CHAIRMAN. When you say strengthen, do you mean give the States more power?

Ms. JONES. No, enforce what they have.

The CHAIRMAN. You have lost me again. What are they not doing that you would like to see changed?

Ms. JONES. May Mr. Christy answer that?

The CHAIRMAN. Yes.

Mr. CHRISTY. What we are trying to do——

The CHAIRMAN. Would you identify yourself?

Mr. CHRISTY. Yes. My name is Jack Christy. I work on health issues for the federal staff of AARP. What we are trying to do, be-

cause the certificate of need is different in each State—there are 19 States in the country that have put an absolute moratorium on new bed construction—so what we are trying to do is to get an information system in place that will give us the knowledge to balance what our community needs are and trying to keep as many people in the community as possible against the need for new beds. And we know with the demographics that are coming that we are going to need new skilled beds. But we don't have a good handle as yet on what the balance is between community's long-term care and the institutional long-term care.

The CHAIRMAN. What I sensed from reading your testimony is that you would like the system changed slightly so that more beds would be built.

Mr. CHRISTY. We are going to need more beds. That is correct, sir.

The CHAIRMAN. So, if any State has a certificate of need system that, in your judgment, results in fewer beds being built than you think ought to be built, you want to reform the system.

Mr. CHRISTY. Not a reform of the system but a very important component. Something that Oregon is exemplary on is the balance they are achieving between their community system and their institutional system. And the progress that has been made in Oregon is not spread around the country.

The CHAIRMAN. But basically your frustration is that you don't think they have reached the right conclusion.

Mr. CHRISTY. About building?

The CHAIRMAN. Yes.

Mr. CHRISTY. In some places, they have. Take Ohio for example, they have a plethora of beds and they are building more. It is going to end up to be a very expensive system. They haven't made any attempt to see if there is a balance between the in-home and the community-based care relative to the institutional care and that is the kind of considerations that have to go into the certificate of need deliberation.

The CHAIRMAN. Let me ask you this. What kind of risks do you think there are in proceeding with prospective payment before we are very well versed with the system? You seem to share, at least, the concern of the two previous gentlemen who don't like prospective payment. They agreed that the system at the moment is so poor that something needs to be done. I assume you share that conclusion, but you are willing to try to go ahead with prospective payments?

Mr. CHRISTY. I think that there are definite problems that are coming up in this new system of prospective payment, but I don't think that that throws the experiment out. If we could get consistency in the commitment to maintaining quality within this system, we could achieve the results that we want—high quality care—and the results that the Government wants—a savings in costs. But when you have the alternative policies criss-crossing for example the elimination of the waiver—the proposal to eliminate the waiver of liability presumption—it just cuts against your prospective because what you are doing is making it so much more difficult for a skilled nursing facility operator to offer a post-acute care bed to somebody that is being pushed out under your policy of DRG that

they slam into each other. If we can get some consistency and moving in the same direction with those kinds of DRG and post-acute policies, then the DRG system with the prospective payment system could run a lot more smoothly.

The CHAIRMAN. Senator Baucus.

Senator BAUCUS. No questions.

The CHAIRMAN. Senator Long.

Senator LONG. I was just looking at the number of skilled nursing facilities in each State, and I see that California has 585 compared to Louisiana with 9, just to make one comparison. Louisiana is on the bottom of the list where you have Oklahoma, and Mississippi, where I guess the situation is about the same. How could you justify so many in California and so few in Louisiana? How could I explain that to my people in Louisiana, that we have so few compared to California, or compared to the national average for that matter?

Mr. CHRISTY. Skilled nursing beds?

Senator LONG. Yes.

Mr. CHRISTY. I think it is a function to a great extent of State attitudes. I mean, certificate of need is controlled at the State level.

Senator LONG. One reason may be that we had a very elaborate health care system in Louisiana prior to the time the Federal Government got into it, and most of the care was provided at State expense. And it may be that we are still providing enough hospital care at State expense that they don't need that much in the way of skilled nursing facilities, but even if that's the case it wouldn't explain the parallel problem in Oklahoma and Mississippi. And I am told that one of the big reasons for the lack of medicare nursing facilities is that most of the facilities we have down there are not under Medicare because, apparently, they don't think they get paid enough under Medicare. Do either one of you know about that?

Mr. CHRISTY. We are not familiar with Louisiana, sir.

Senator LONG. I see. In these States that have a much smaller percentage of the Nation's skilled nursing facilities than their percentage of the U.S. population can, it seems to me, make almost a prime facie case that they need additional facilities. Looking at this chart, for example, if Louisiana has almost 2 percent of the elderly population and we only have one-quarter of 1 percent of the facilities, then it seems to me as though if someone wanted to put one in, just on the face of it, you would have a case for an additional skilled nursing facility, wouldn't you?

Mr. CHRISTY. We don't have that data in front of us.

Senator LONG. But this chart I was just looking at shows we have nine facilities, and that is 0.26 percent—one-quarter of 1 percent—of those facilities in America, while we in Louisiana have about 2 percent of the population. It seems to me as though we could justify 10 times what we have.

Ms. JONES. I can't answer that directly, Senator, but I have read some studies on hospital use in contiguous counties in Michigan, and they vary in their use from 800 average days to 1,200 average days, and there is a feeling that there is not any reason for this because the explanation is not apparent through the diagnoses of patients, the types of people that live in these counties, the climate even in Michigan, and the general environment. So, there are vari-

ations in health care services across the country and a variation in the way those services are used that are not explainable.

Senator LONG. Thank you very much.

The CHAIRMAN. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman. In your testimony, you say, Ms. Jones, on page 2: The Medicare DRG system is pushing beneficiaries out of hospitals sooner and sicker. Is that true? What do you have to base that on? And I am not taking an opposite point of view. I am just curious as to where you got this information because, as you know, I thought the jury was still out on that, but you have come to a conclusion.

Ms. JONES. In actuality, I think a jury has to be still out on DRG's. Nevertheless, what happens to be—what you see happening is people being dismissed or discharged from the hospital and the nursing home industry, giving us information about their problem in meeting the demand for service, some rather unfortunate things have been occurring and, because I was active in an organization known as Citizens for Better Care, which had an onwards approach to the nursing care industry, I was able to get the information about some of these things where people had been discharged and had found difficulty in getting access. I also worked on a task force for nursing home reimbursement under Medicaid and learned then of some discriminations against Medicaid and Medicare patients to the point where we recommended that they be required—that nursing homes be required—to utilize a percentage of their beds for Medicare and Medicaid patients in our State. It is not a new problem but it is exacerbated by the early discharge of patients, and I am not sure that that is due to the DRG system. I have certain kinds of feelings that if we had ethical concerns for the well being of patients, we wouldn't be saying you have to leave because your DRG has run out, and that has been said to some patients because that isn't true. The DRG system does not require that the hospital have the patient leave. It only will pay so much, and it is based on an average. And I think looked at adequately that the DRG system would not be under that kind of comment which I perhaps unfortunately made.

Senator CHAFEE. All right. Fine. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Are there any other questions? Thank you very much. I hope you catch your plane.

Ms. JONES. Thank you, Mr. Chairman

The CHAIRMAN. Now, we will conclude with Mr. Lawrence Bartlett, the president of the Health Systems Research, Inc., in Washington. Mr. Bartlett?

[Ms. Jones' prepared written statement follows:]

Prepared Statement of the American Association of Retired Persons

Thank you, Mr. Chairman, for this opportunity to state the American Association of Retired Persons' views concerning the development of a prospective payment system for skilled nursing facilities (SNFs) participating in the Medicare Program. The Association is indeed pleased to set-forth our views on the kinds of issues that must be considered as Congress moves towards establishing a prospective payment system for SNFs. My testimony this morning will outline the issues AARP believes make a difference in the efficacy of a prospective payment system for SNFs to assure appropriate, high quality care as well as contain nursing home costs.

Why Prospective Payment for SNFs

AARP has long been an advocate of prospective payment for the health care sector of the economy. Prospective payment systems contain costs by sharing the financial risk of medical treatment more appropriately between patient, insurer and provider. Thus, despite the Association's strong reservations that the federal DRG system applies only to Medicare patients, the Association supported the implementation of PPS for Medicare beneficiaries needing hospital care. Similarly, the Association supports the development of a prospective payment system for nursing home care. A prospective payment system for skilled nursing facilities participating in Medicare

is desirable for several reasons:

* The current Medicare SNF benefit is not reliable. There is such a wide variation in the interpretation of the criteria for Medicare coverage in a skilled nursing facility that patients with identical problems too often do not receive equal coverage. The small level of Medicare expenditures on nursing home care is probative of this point. Grounding a new prospective payment system on clear standards of eligibility for SNF coverage would be a vast improvement over the current system.
* It makes good policy sense to treat all Medicare Part A services on a consistent basis to avoid unbundling of services and to prevent perverse payment and level of care decisions.
* The Medicare DRG system is pushing beneficiaries out of hospitals sooner and sicker. Medicare patients need a place to go upon discharge from the hospital to fully recover. Skilled nursing facilities and home health services must be made commensurate to the demands placed upon them by the DRG system. A well-conceived prospective payment system for skilled nursing facilities will help assure that beneficiaries have a place to receive quality nursing home care.

Making Choices

Developing a prospective payment system for SNFs is an exercise

of choices. Should the system have a flat rate per case, for example, determined independently of the facility's costs or should the rate be cost based, facility specific? How should the rate base be determined? By a fixed method that favors the "system" over time, or by a progressive base that favors the facility over time? What are the incentives created by the choices available? Unlike the acute care sector, the data upon which to make informed choices about many important issues concerning nursing home care is often lacking. Policymakers need a great deal more information and analysis about nursing homes and patients before a stable and reliable prospective payment system for SNFs can be constructed and implemented.

A basic question facing policymakers is whether payment rates should vary with facility and patient characteristics. AARP favors a combination flat rate and case mix approach to establishing the basis of payment. The Association fears that failure to gear case payment to the actual resource needs of the patient will result in nursing homes skimming light care patients and foreclose access to nursing homes for heavy care patients.

Choices must also be made about the variables by which case mix is to be measured. In the nursing home setting, diagnosis alone is not a sufficient indicator of resource use to be useful as a basis of payment. The case mix system must be grounded on realistic, verifiable evaluations of residents' care needs that include behavior and psychosocial/quality of life factors, as well as nursing care needs. Payment should be at a level sufficient to support good care.

Improving Patient Information Systems

For case mix to work, the entire system of care within the nursing home and the regulation of that care must focus on the actual care individual residents need and receive. Thus, before Medicare patients invest their confidence in a prospective payment system for skilled nursing facilities, a reliable patient care management system and a system for measuring outcomes must be developed. Such a system must be able to effectively measure: quality, appropriateness, medical necessity, and the utility of nursing care provided. The Inspection of Care (IOC) process could, for example, be improved to measure both the appropriateness of residents' care classifications and the quality of care they receive. (IOC findings should be utilized by the survey agency in making its recertification determinations.) It does little good to finally have "heavy" care patients admitted to nursing homes, if nursing homes do not staff up to provide "heavier care". A stronger Inspection of Care process could assure that SNFs are actually providing the level of care appropriate to the nursing home resident.

Capital Costs and a Workable Con Process

A prospective payment system for skilled nursing facilities must include payments for capital. The objective of capital payment policy should be to assure an adequate supply of quality SNF beds over time and to maintain, as much as possible, a continuity

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of ownership over time. The well-documented trafficking in nursing homes has not served nursing home residents and other payers of care well.

The Omnibus Deficit Reduction Act of 1984 begins to address the "step-up" upon sale problem by limiting capital related costs to the new owner to the lessor of the cost to the original owner or the purchase price. Despite this improvement in Medicare, AARP believes that the traditional method of paying for capital - allowances for interest and depreciation - will not provide the SNF beds necessary to meet the needs of an aging population.

The Association is interested in the "fair market rental" concept used to pay nursing home capital costs in Maryland and West Virginia. AARP is cautious, however, of the cost of this capital payment methodology over time - especially for nursing homes built in a period of high inflation. Any nursing home capital payment method must be fair to both investors and to the payers of nursing home care. Full recognition of all issues surrounding capital payment is a necessary prerequisite to developing a good capital payment mechanism for Medicare.

Closely related to capital payment is the development of an adequate certificate of need criteria to guide the construction of additional bed capacity. Such criteria must include a better understanding of the relationship between institutional care and community and home based care. Only then will policymakers be in a position to assess the real need for more institutional beds. The federal

government could make a major contribution towards achieving this understanding by loosening the regulatory constraints on the Medicaid, Section 2176 waiver program.

Prospective Payment System - Relation to the Regulatory System

A well-conceived prospective payment system for SNFs can provide incentives that will enhance both access to and the quality of nursing home care. But even the best payment system cannot do all that is necessary to assure consistent, accessible, quality nursing home care. A strong regulatory system is essential to assuring that nursing home residents receive the care they need. This point was graphically made during a hearing by the Senate Special Committee on Aging, titled: Quality Assurance Under Prospective Payment Systems held in February 1983. The Association believes there must be a close link between nursing home payment and the regulatory system. We shall seek legislation that relates payment to the standards of care, licensing and enforcement.

Appeals

Medicare's change from a cost-based system of payment to a prospective system of payment dramatically alters the potential liability of Medicare beneficiaries. This is true under the DRG system and is likely to be true under a prospective payment system for skilled nursing facilities. Hence, it is essential that the appeal procedures available to beneficiaries be enhanced to reflect

their greater liability under the prospective payment system. At a very minimum, the basis of decisions concerning eligibility for care and financial liability for services must be recorded and available to the public.

Conclusion

On behalf of the 18 million members of the American Association of Retired Persons, I want to thank you again, Mr. Chairman, for this opportunity to testify about this important area of public policy. As consumers of nursing home services and as taxpayers, our members have a vital interest in this subject. We look forward to working with you, the Administration and the nursing home industry, to develop a nursing home payment system for Medicare that will meet our country's nursing care needs at an affordable price.

STATEMENT OF LAWRENCE R. BARTLETT, PRESIDENT, HEALTH SYSTEMS RESEARCH, INC., WASHINGTON, DC

Mr. BARTLETT. Thank you, Mr. Chairman and members of the committee. I would like to add my name to the list of individuals who have come before you today and stated that in their belief there is in fact an access problem with the Medicare SNF benefit—a very serious problem. HCFA's own data in their report indicates that there is great variation in the utilization of this benefit across the States, ranging from a high of 635 days per thousand elderly Medicare beneficiaries in the State of Kentucky to a low of only 1 day per thousand elderly beneficiaries in Wyoming. If that data doesn't indicate that there is an access problem somewhere in the United States—in at least one State in the Union—then I don't know what access problems really are. In addition, although the jury is still out in terms of the eventual impact of the DRG system in terms of the demand for nursing home care, I think economic theory and perhaps gut feelings indicate that it may increase the demand for post-acute care services. If so, this will only push the problem of access further.

I would like to spend the majority of my time ticking off the underlying causes of these access problems and spend a little bit of time talking about what the range of possible solutions might be to this problem. I guess the bottom line that I would arrive at is that focusing solely on prospective reimbursement for the Medicare SNF benefit may be putting all your eggs in one basket and may not really solve your access problem.

If we go back to the reasons for the current access problem—and you have heard them from other witnesses today—I would say that they fall into three categories. First, as you have heard, current average costs of Medicare reimbursement may in fact not be sufficient to cover the costs of Medicare patients who may have more intensive care needs.

Second, the interpretation of the Medicare SNF coverage policies is by no means consistent across the Nation. The erratic administration of the SNF benefit by the different Medicare intermediaries requires nursing homes to guess about whether Medicare patients will eventually be approved for coverage by their intermediary. The penalty for guessing wrong is possible financial exposure for the nursing home. There was a study done several years ago by Bill Scanlon and Judy Feder that tried to provide a sense of the variation in making consistent coverage definitions. They developed records on nine hypothetical cases and gave these cases to 12 Medicare intermediaries, 5 PSRO's, and a representative from HCFA's Office of Direct Reimbursement. They asked these parties to determine if these cases were eligible for Medicare SNF coverage or not. What they found was substantial variation. Three of the reviewers said that they would cover only three or four of these cases. Eight said that they would cover eight or perhaps all nine of the cases. And even in the gray area where several reviewers agreed on the same absolute number of cases, in fact they picked different cases. While several reviewers might say yes, we would cover four of these cases, they each picked different cases.

This finding really highlights the fact that there really is no consistent interpretation. The Medicare eligibility criteria are very complex, but the fact of the matter is that the intermediaries hold all the cards in the final decision and a nursing home up front has to guess whether or not coverage is going to be granted. The options are to: take their chances and perhaps try to recoup funds from the patient if the intermediary denies coverage, push for Medicaid coverage, or go directly for private pay.

The third major problem with access to the Medicare SNF benefit is due to the fact that Medicare is really small potatoes in the nursing home field. It is State government—through its role as a Medicaid program administrator—that is really the E.F. Hutton of the long-term care world—when they talk, the nursing homes listen. They must attempt to control Medicaid long-term care costs and deal with the inconsistencies that the Medicare intermediaries force upon the States—in the sense that you gentlemen in 1977 passed legislation requiring a common definition of SNF coverage criteria and certification requirements between Medicare and Medicaid. But a number of States have responded to cost containment pressures and these inconsistencies by moving away from SNF coverage. Senator Long asked the question why Louisiana has so few SNF facilities participating in Medicare. Senator, your problem is the same as Senator Dole's problem in Kansas in that more than 95 percent—I think in your case I believe it is 98 percent—of all the nursing home care that is provided in the State of Louisiana is ICF level care. There are very few days of care that are paid, either for Medicaid or Medicare patients, that are SNF care. If you try to figure out why, it is perhaps because the State tried to keep down its reimbursement rates and recertified homes from SNF to ICF level care to break this link with Medicare which may have been causing problems for them. It is very difficult for a State to justify providing Medicaid SNF benefits to a patient who has just been denied SNF coverage by a Medicare intermediary. Some States have dealt with by saying, OK, we are just not going to confront that issue, and we will move off to ICF coverage. As a result of this and cost containment measures, there are also States in the Union which have 98 percent of all their nursing home beds certified to ICF level beds. There are also States in the Union that have 98 percent of all their nursing home beds classified or certified as SNF level beds. So, there is a great disparity in terms of access to SNF level beds across the Nation that has nothing to do with Medicare policies. It is the result of State level policies concerning long-term care and cost containment.

If we see these as the general reasons for the Medicare SNF access problems, let me just suggest that a prospective payment system may not really handle all these problems. It will certainly address the first cause, which is the fact that reimbursement levels may be unduly low and may not cover the cost of caring for Medicare patients. I would argue that several other things are necessary, and they should be explored as possible solutions. The first would be the standardization and perhaps centralization of the Medicare SNF coverage determination process. And if I can just illustrate for a moment——

The CHAIRMAN. I am going to have to ask you to wind down. I don't want you to provide us with numerous illustrations.

Mr. BARTLETT. Certainly.

Senator LONG. I would like to hear that illustration, if you don't mind.

Mr. BARTLETT. Let's assume that it costs $30 to care for a Medicare beneficiary, and that under your current reimbursement system you are paying $25. If you jump it up to $30, you will be providing additional funding for those Medicare SNF patients that would otherwise be accepted because the nursing home is fairly comfortable that they would need to meet the Medicare coverage criteria and they will get Medicare reimbursement. But there are patients in gray areas for which the nursing home is really not sure whether or not they will get coverage. For these, let's say it is a crap shoot—it is 50-50—whether the intermediary will come back and say, yes, they are eligible for coverage, or no, they are not. If you are paying $25 now and the probability is 50 percent that they will get money back from Medicare, then the effective return that they can anticipate is $12.50 for that gray area patient, not enough to make them take them. If you raise it to $30 and don't deal with the problems of the uncertainty about the retrospective determination, you still have that 50-50 probability. Then it is $30 times 0.5 probability, which gives you an anticipated payback of $15. They are still not going to take those gray area patients. So, I would argue that you have to look at the issue of the great variation in the eligibility determination process as well. You might want to look at dual participation requirements and several other options which I describe in further detail in my written remarks.

[Mr. Bartlett's prepared written statement follows:]

PREPARED STATEMENT OF LAWRENCE R. BARTLETT

Dear Mr. Chairman and Members of the Subcommittee:

My name is Lawrence Bartlett and I am director of Health Systems Research, Inc., a Washington, D.C. consulting firm that works closely with state and federal government on Medicaid and long-term care issues. Prior to this I served as staff director of the State Medicaid Directors Association. I am pleased to have the opportunity to share with you my views on the Administration's study of the Medicare skilled nursing facility (SNF) benefit and the proposal to establish a prospective reimbursement system for this benefit.

I found the Administration's report to contain a wealth of information concerning the Medicare SNF benefit and -- in keeping with the mandate set forth in TEFRA, the 1983 Social Security Amendments, and DEFRA -- to focus on the need for a better method of reimbursement for this benefit.

However, it was perhaps because of the vast amount of data presented in the report as well as its emphasis on reimbursement changes, that as I read it I was drawn back to a few very basic questions: "What are the problems with the Medicare SNF benefit that need to be fixed? Will a prospective reimbursement system solve these problems?

Unlike our experience with the Medicare inpatient hospital benefit, it appears that the interest in moving toward a prospective reimbursement system for Medicare SNF care is not driven by overwhelming and unacceptable cost increases in this benefit. Per diem payment levels increased at an annual rate of 7.7%

between 1975-1983, below the 8.3% rate of growth in the cost of nursing home inputs. Total Medicare SNF expenditures during this period increased at about the same rate as the costs of inputs, this is due in part to a rise in the number of covered days during 1981-1983. However, even with this recent increase in utilization of the SNF benefit, covered days per 1,000 Medicare beneficiaries in 1983 were nearly 15% below 1973 utilization levels.

The problem we seek to address in the Medicare SNF benefit is one of access. Although every Medicare beneficiary in the United States is entitled to up to 100 days of post-acute SNF coverage per spell of illness, the reality is that these benefits are not available to Medicare beneficiaries in many parts of this country. In effect, Medicare beneficiaries in these areas do not have the coverage they thought they had -- they're not getting what they thought they paid for.

Understandably, our anxiety over this situation is exacerbated by the feeling that the Medicare inpatient hospital prospective payment system will provide hospitals with strong incentives to discharge Medicare patients to less intensive settings as early as possible. Should this occur, as anecdotal evidence suggests it is, the demand for SNF care for Medicare beneficiaries will increase. Unfortunately, there may be few nursing homes willing to accept Medicare reimbursement for these individuals. The end result may be that some Medicare beneficiaries who would most appropriately be treated in a SNF would:

- remain in the hospital;
- be sent home prematurely, perhaps with some Medicare-funded home health benefits; or
- be forced to enter a nursing home as either a private pay or a Medicaid patients, if they were eligible.

At the risk of repeating points you may already have heard in the testimony of earlier witnesses, I would like to summarize the main reasons these access problems exist. They include the following:

1. Medicare's current reimbursement methodology may not generate rates sufficient to cover the cost of caring for Medicare beneficiaries. Although in most states, Medicare SNF rates exceed those paid under the Medicaid program, evidence suggests that the Medicare's reimbursement for "average" costs may not cover the cost of caring for Medicare patients who may have higher than average care needs. Additionally, the retrospective, cost-based nature of the Medicare approach offers no incentive for nursing homes to be efficient in the treatment of patients.

2. The administration of Medicare's SNF benefit makes the admission of Medicare patients unattractive to skilled nursing facilities. The manner in which the Medicare SNF benefit is administered places a considerable burden as well as a considerable amount of risk on SNF's. As was pointed out in a 1981 study of the Medicare SNF benefit conducted by Judith Feder and William

Scanlon, now at the Georgetown University Center for Health Policy Studies, this occurs in several ways:

a. Certification requirements may be more stringently enforced for Medicare than for Medicaid. In spite of the fact that 1972 legislation (P.L. 92-603) required Medicare and Medicaid to have identical definitions and certification requirements, Medicare's enforcement of these requirements particularly staffing requirements may be more stringent that those under some state Medicaid programs. Thus, a facility's decision to participate in Medicare in addition to Medicaid might require it to increase its costs, without necessarily having these costs fully covered by Medicare's reimbursement rates.

b. Determination of eligibility for Medicare coverage may be delayed. A nursing home that admits a Medicare-eligible patient is required to contact its Medicare intermediary to determine that the patient has not exhausted the number of days in his/her current benefit period or spell of illness. The intermediaries will check with HCFA central office concerning the number of SNF days billed to date and will report back to the nursing home on the number of days remaining in the SNF benefit. While intermediaries report that the turn-around time for this information is usually within one week, some nursing homes indicated they typically must

wait 30 days or longer for the receipt of this information. Given the short average length of stay for Medicare beneficiaries in SNFs, many of these patients may have already been discharged before this information on benefit availability is received from the intermediary.

c. Wide variations exist in the interpretation of Medicare's SNF coverage criteria. An even greater cause of uncertainty for nursing homes is the very uneven manner in which intermediaries interpret Medicare's definition of when skilled nursing facility care is appropriate. These guidelines involve very complex coverage criteria -- such as determining "rehabilitation potential" and a "high probability, as opposed to possibility" of complications of conditions -- that are subject to widely different interpretations by Medicare intermediaries.

As evidence of this problem, Feder and Scanlon cite the results of a study in which claims reviewers in a dozen Medicare intermediares, five PSRO's, and Medicare's Office of Direct Reimbursement were asked to review 9 cases designed to test the consistency of their judgments. They found that the reviewers made very different coverage decisions when reviewing the same cases. Three of the reviewers would have covered only three or

four of the nine cases. Eight of the reviewers would have covered sevenor eight of the nine cases. In addition, reviewers who covered similar numbers of cases did not cover or deny the same cases.

Clearly, this degree of inconsistency would make nursing homes hesitant to admit Medicare patients because they may find themselves at financial risk as the vagaries of intermediary decision-making. According to Medicare requirements, nursing homes are denied payment for erroneous or denied cases if the number of these days exceeds 5% of the total number of Medicare days covered in the previous quarter.

3. The nursing home market is driven by Medicaid policies - Medicare plays a very minor role. Skilled nursing facility operators might be willing to put up with possibly low Medicare reimbursement rates and the unpredictability of intermediary coverage decisions and the attendant financial risks if Medicare patients represented a substantial portion of their business.

However, Medicare expenditures for SNF care represent less than 2% of all payments made to nursing homes -- a fact of which we should not lose sight. In contrast, Medicaid program payments account for approximately 43% of total nursing home revenues.

Because of its size, Medicaid considerations drive the nursing home market. In many jurisdictions, state actions taken

to control Medicaid expenditures or avoid confrontations around flip-flopping intermediary decision-making may have further exacerbated problems with the SNF Medicare benefit. These include:

- In an effort to control rising Medicaid expenditures, many states have moved to constrain the supply of nursing home beds, some having established moratoria on the construction of new beds. Admission delays caused by a shortage of beds and waiting lists are likely to affect the shorter-stay Medicare beneficiary more seriously than longer-stay Medicare patients. By the time a bed opens up, the Medicare beneficiary may no longer qualify for the Medicare definition of SNF care.

- Perhaps as the result of efforts to reduce per diem levels and/or avoid the possibility of federal fiscal disallowances for providing Medicaid SNF coverage for patients who had earlier been denied Medicare coverage by the intermediary under theoretically joint Medicare-Medicaid coverage standards, in some states the vast majority of nursing home beds (and therefore care) have been classified as lower level intermediate care facility (ICF) services and not SNF care. In Oklahome, Kansas, and Louisiana, over 95% of all nursing home care provided is ICF level care. In these states, the availability, and therefore the utilization, of SNFs by

either Medicare, Medicaid or private pay patients, is very low.

If we agree with this assessment of the causes of the SNF access problem, then we must ask ourselves if this report is proposing a solution that will really remedy the problem. I think not. The development of a prospective payment system for the Medicare SNF benefit may make the Medicare patient marginally more attractive to nursing homes. By itself, however, it will do very little to address the other problems I have identified -- such as the delays and inconsistencies in intermediary eligibility and coverage determinations, and the shortage -- not only of Medicare-certified SNFs -- but of any type of SNF beds in many parts of the country.

Therefore, if our goal is to provide a valuable post-acute care nursing home benefit that is truly available to all Medicare beneficiaries nationwide, I would suggest that the following avenues also be explored:

- The standardization, and perhaps centralization, of the Medicare coverage determination process. Standardization would involve more intensive training of intermediary claims reviewers to develop greater accuracy and consistency in making coveratge determinations. Centralization of this process at HCFA Central Office or some other site would likely reduce the variability in decision-making that presently exists across the

approximately 80 Medicare intermediaries and related groups.

- Review of waiver liability provisions to develop a more balanced approach tha leaves SNFs less exposed to the vagaries of intermediary decision-making.

- The establishment of a dual participation mandate that would require SNFs participating in Medicaid to also participate in Medicare. This may improve access Medicare SNF care in certain states, particularly if coupled with the changes described above.

- Review the validity of the SNF-ICF distinction for Medicare reimbursement purposes. Requiring dual participation will not substantially improve access in these states in which nearly all their beds are certified for ICF care. It is difficult to imagine that the needs of these states' populations are so territorily different from those in states with nearly all SNF beds. Careful study of the real distinctions between SNF and ICF care should be undertaken to determine what can be done about Medicare SNF access in predominantly ICF care states.

The CHAIRMAN. You indicate that we may have a solution to the problem; that is you recommend that if you take Medicaid patients you must take Medicare patients. What are the up and the down sides to that?

Mr. BARTLETT. If you did solely that, Senator, I think the argument can be made that certain facilities—You might exacerbate the access problem, in that with all the requirements, with all the uncertainty, there may in fact be skilled nursing facilities that might in fact change their status or sort of drop down to ICF coverage—if in fact you don't do anything in terms of the great risk that they are placed at because of the retrospective determinations.

The CHAIRMAN. They would drop down to the ICF and still skip the Medicare?

Mr. BARTLETT. And still skip the Medicare. Yes.

The CHAIRMAN. Just attempt to keep their status and keep whatever Medicaid money they had coming in ICF?

Mr. BARTLETT. Yes, and I guess that is my final point in terms of the kinds of things to look at—would be to just explore this whole notion of SNF versus ICF distinction for the purpose of Medicare reimbursement. I find it very difficult to imagine that the health care needs of the population in Oklahoma or Louisiana, which get 98 percent of the care at the ICF level, is that different from the health care needs of the population in California where 98 percent of the nursing home care is SNF level care.

The CHAIRMAN. I have to confess I have never figured out why we have left out the ICF. We go down to home health care to take care of part of that, skip the ICF's, go up to the skilled nursing facilities, up to the hospitals. It is as if you have left out a part of the building block for no apparent reason.

Mr. BARTLETT. The ICF benefit was somewhat of a late-comer to the Medicaid Program.

The CHAIRMAN. Yes, I understand that.

Mr. BARTLETT. And I guess when you have access problems, perhaps you don't have as bad a cost problem as you might, and perhaps it is left out for that reason.

The CHAIRMAN. Senator Long?

Senator LONG. I was manager of the bill to put Medicare and Medicaid into effect. Back at that time, we had witnesses testifying before us about how the program should work, and it all sounded very simple. Of course, they were talking about what an ideal system ought to be, and so you put the person in the hospital, and when the person needs a convalescing period, you move him from the hospital over into the nursing home. It is all very simple. There is nothing to it. Now, of course, after we passed the bill—the first year after—we had a cost explosion that went far beyond what anybody anticipated. Really, I think lack of foresight is the problem. There is no reason why anybody should have failed to anticipate that when the Government starts paying for all this, you are going to have a lot more people that ask for the service than you had before the Government was paying. If the Government will pay it, all kinds of people are going to apply who wouldn't be there if they had to pay $100 a day for it, or a lot more than that. If we had been able to anticipate the cost to begin with, it might have been a far more sensible approach to put a program into effect that

moved the patients from the hospital over into the SNF and into the lower level of nursing homes. And it is sad to find us talking about a situation where needed facilities aren't being built. In my State they are not available, and I guess there is a shortage in more than half of the States. And the testimony that I am hearing here today tells me that all over the country the administrators see the people come and apply for admission, and these administrators have to sit there and think in terms of cost and how much will be paid. "Do you think we will make money on this one or do you think we will lose money? If we are not going to make money, I think we ought to turn this person down". That is a tragedy—a human tragedy for people when you think of pitiful, suffering souls out there who can't get the care that they ought to have. It makes me think if we started all over again, we could have done a lot better, even if only by requiring people who can afford to pay something to pay for part of their cost. Anyway, if you have some more ideas, I wish you would let us know.

Mr. BARTLETT. I think the basic problem is that the statute perhaps very eloquently tries to set up standards or parameters for provision of this coverage, but the failure is really in the way the benefit is administered. It may be different in Oregon as compared to Florida. On paper we supposedly have a national benefit—100 days of SNF care—but because the way it is being implemented, folks in your State may not be able to touch it. That's why I think it is as much a failure in execution, perhaps more so, as it a failure in program design. And I think it can be addressed.

Senator LONG. Thank you very much.

The CHAIRMAN. Your testimony, which I read this morning, was excellent. I appreciate it. It is very cogent. You obviously know this subject well.

Mr. BARTLETT. Thank you, sir.

The CHAIRMAN. Thank you. We are adjourned.

[Whereupon, at 11:25 a.m., the hearing was adjourned.]

[Dr. Davis' answers to questions from Senators Durenberger and Dole and the statement of the American Hospital Association follow:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

JUN 4 1985

The Honorable Bob Packwood
Chairman, Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Enclosed are responses to questions submitted to me by Senators Dole and Durenberger for inclusion in the record of the April 17 hearing on prospective payment for Medicare skilled nursing facilities. I appreciate the opportunity to present the Administration's views on these issues.

Sincerely yours,

Carolyne K. Davis, Ph.D.

Enclosure

Questions Submitted for the Record
by Senator David Durenberger

1. Q. Many nursing homes cite the cost reporting requirements as one of the biggest deterrents for participation in Medicare.

   -- Why is the cost reporting such a burden to providers?

   -- What can we do to ease up the cost reporting load yet still get the information we need?

   -- What information do we need to collect in order to implement a prospective payment system for SNF providers?

   A. For several years, HCFA has been using a "one-form-for-both-hospital-and-SNF" cost report concept. This approach was in response to concerns from the hospital and SNF industry that the cost report be compatible for use by both institutions.

   However, this cost report now requests much more information than necessary from freestanding SNFs. Consequently, we have been developing a separate cost report which is more suitable for freestanding SNFs and expect it to be available later this year.

   As part of the revision to the SNF cost report, we are also considering possible reductions in the data items requested on the cost report. We are also considering the transfer of data electronically to eliminate the preparation of volumnious hard copy reports.

   Regarding the information necessary to implement a SNF prospective payment system, the data requirements will vary depending on the type of system. Any prospective payment system with casemix-adjusted rates would probably require collection of ADL (activities of daily living) dependency scores on all Medicare SNF beneficiaries. Such data are not currently collected. Before implementing such a system, we would need to know whether the improvements to be gained from a casemix-adjusted prospective payment system would be sufficient to justify the administrative burden and cost of collecting these additional data.

2. Q. Fiscal intermediaries have a wide variation in how they interpret the Medicare SNF benefit and coverage decisions.

-- Why is the SNF benefit so difficult to administer?

-- Will the proposed regulations to eliminate the waiver of liability for claim denials be a further deterrent to SNF participation?

-- Has the Administration thought about reducing the number of fiscal intermediaries for SNFs similar to what we are doing for home health providers? Would this help in administering more uniform benefits?

A. In examining the administration of the SNF benefit, it is important to look at the statutory requirements that form the framework of the benefit. The SNF benefit is not intended to be a long term nursing home benefit but covers the need for relatively short term skilled nursing care following an episode of hospital care. In addition to the statutory requirements that an individual have a qualifying three-day prior hospital stay and be admitted to a SNF within thirty days of hospital discharge, there are other statutory requirements as well that make the administration of the benefit more complicated than may be apparent upon first examination.

The focus of the benefit is that the care received in a SNF be skilled in nature. In order to make the determination of whether skilled care is being furnished, the care rendered an individual must meet the following conditions: (1) the care must be provided on a daily basis, (2) the skilled nursing care or other skilled rehabilitation services must be for any of the conditions for which the individual received medically necessary inpatient hospital care, or for a condition which arose while an inpatient of the SNF, and (3) such services can be provided, as a practical matter only in a SNF. All of these requirements must be met before an individual can be said to require skilled nursing facility care.

On a practical level, each SNF case must be judged on its own merits. That is, it is necessary to look at each case separately and determine whether within the framework of the statute and regulations the individual in question does indeed require SNF care. It has been our experience, since the inception of the program, that these decisions require a close balancing of medical, nursing, and social factors. I would also add that reasonable people can differ in their judgements.

I do not believe that the proposed regulations concerning the waiver of liability provision will deter SNFs from participating in the Medicare program. It is important to note that the regulations would not eliminate the waiver; they would eliminate the presumptions under which it is currently administered. That is, payment could still be made for noncovered care if the SNF did

not know or have reason to know that payment would be denied, however, we would not presume that it did not know, as we do now, on the basis of a low denial rate.

As a result of the current mode of administration, SNFs have developed a good sense of what is covered and most SNFs are highly successful in identifying cases which Medicare will cover. I realize that the industry is somewhat insecure about our proposed change, but believe that it will not create the problems some critics anticipate. However, I have designated a task force within HCFA to review the waiver of liability regulation and concerns raised by the industry.

We do not believe that the consolidation of SNF intermediaries should be made without an analysis of the need for such a change. Because of the relatively small number of SNFs, a reduction in the number of intermediaries would on its face appear advisable. However, we need to study if the nature of SNF coverage decisions would require consolidation for uniformity, which was the purpose of reducing the number of HHA intermediaries. If such a course is decided upon, it would require legislation to eliminate the SNF intermediary nomination process.

3. Q. How would a prospective payment system affect the current distribution of the SNF benefit and the behavior of the nursing home industry? How soon can we implement a prospective system? What is your opinion of the industry's proposed "transitional" prospective payment system for SNFs? Do we have the information needed now to implement such a system?

A. HCFA believes that the effects of Medicare SNF prospective payment on the distribution of the Medicare SNF benefit and the behavior of the nursing home industry would be modest. While prospective payment would likely provide some incentives for greater Medicare participation, it must be remembered that Medicare represents only 2 percent of the nursing home market. Thus, in States where the Medicaid program is heavily oriented toward ICF-level care, there would probably still not be enough potential Medicare patients to induce a substantial increase in nursing homes to offering skilled nursing services.

A prospective payment system based on individual facility-specific rates up to the cost limits as proposed by the industry could be implemented in a few months' time. Any more substantial reform involving casemix adjusted payments or some sort of DRG add-on must be thoroughly researched to determine its feasibility and, thus, could not likely be implemented in less than three years.

HCFA is currently conducting cost analyses to estimate the impact of the American Health Care Association (AHCA) proposal. Our preliminary evaluation of the plan is that the overall approach proposed does not address many of the issues we would need to see in a prospective payment system, such as incentives to admit heavy-care patients.

No new information would need to be collected to implement individual facility-specific prospective payment.

4. Q. The SNF report talks about the need to further understand the use of other post-hospital Medicare services like rehabilitation hospitals, rehabilitation units and swing beds before changing the SNF benefit.

   -- Is the administration currently studying the use of these post-hospital services and how they relate to hospital PPS?

   -- Is there any information on use of these services by diagnosis?

   A. In September 1984, HCFA awarded a cooperative agreement to the Medical College of Wisconsin (MCW) to investigate the feasibility of a case-mix classification system for Medicare reimbursement of rehabilitation hospitals and units. Working with the Rand/UCLA Health Financing Policy Research Center, MCW will obtain rehabilitation patient-record and cost data from approximately 8,000 medical charts at 100 rehabilitation hospitals and units nationwide. As part of this study they will explore the feasibility of using diagnosis as a component in a case-mix system. The findings from this project will be included in a December 1985 report to Congress which will include a section on incorporating exempt hospitals (such as rehabilitation hospitals) into the Medicare prospective payment system.

   An evaluation of the rural swing-bed program is being carried out by the University of Colorado to meet the mandate of the Omnibus Reconciliation Act of 1980 (P.L. 96-499). This study (due in mid-1986) will address the following issues: (1) the impact of the swing-bed program on access to long term care services in rural areas; (2) the quality of care furnished to long term care patients in a hospital setting; (3) the effects on costs at the case, hospital, and program levels; and (4) the administrative costs of monitoring and administering the program. We are currently considering the feasibility of expanding this study to evaluate the impact on the swing-bed program of the Medicare prospective payment system for hospital services.

   In addition to the information on diagnoses and service use in the above studies, there are data on these variables in the Medicare statistical system.

5. Q. I understand that the last regulations published concerning SNF payment were published September of 1982. These regulations established the single reimbursement rate for hospital-based and freestanding SNFs. However, the single rate was delayed and subsequently replaced by the dual limits established by DEFRA yet no further regulations have been published.

-- How are the 80 fiscal intermediaries paying for SNF care today? Under what authority?

A. We have issued interim instructions for our intermediaries to use for payment of hospital-based SNFs in compliance with the Deficit Reduction Act. The cost limits for freestanding SNFs as published in September 1982 have not been revised. We are developing a notice to finalize the cost limits for hospital-based SNFs required in DEFRA.

Questions Submitted for the Record

by Senator Robert J. Dole

1. Q. What is the status of your report containing specific recommendations regarding changes in our reimbursement for SNFs?

   A. On April 16 we submitted to Congress a report on the "Study of the Skilled Nursing Facility Benefit Under Medicare." The report presents analyses of the current benefit, the structure of the industry, differences between hospital-based and freestanding SNFs and reimbursement issues. The report's key conclusions were that no reliable and valid patient-specific case mix measure presently exists for Medicare SNF patients that can be used in developing a prospective payment system, and changes in Medicare SNF reimbursement are not likely to have a large impact on nursing homes since Medicaid dominates the nursing home industry.

   We have commissioned research on the feasibility of various options for prospective payment for Medicare SNFs which might be recommended. For example, HCFA has funded two projects researching the applicability of "RUGs" (resource utilization groups) as a casemix measure that could serve as the analog to DRGs in a prospective payment system for SNFs. Final results from these studies will be available in the late fall of 1985. HCFA has also contracted with the Rand Corporation to design a demonstration of an add-on to the hospital DRG payment for Medicare skilled nursing facility care. This approach will take at least 5 years to yield results. Clearly, HCFA cannot produce a report recommending either of these options until their feasibility has been researched.

2. Q. What do we know about the impact of the new DRG system has had on the type of patient being cared for in a skilled nursing facility? Are there more discharges to SNFs?

A. We do not have any information on whether the type of patient cared for in SNFs has changed as a result of hospital prospective payment. However, we have solicited projects to study the impact of prospective payment on long-term care needs and services and expect to fund projects by September.

In addition, the Office of the Assistant Secretary for Planning and Evaluation of the Department has a contract with the Urban Institute to develop an evaluation strategy for investigating the impact of PPS on the long term care population and the long term care system. This study will examine the extent and the manner in which implementation of PPS has altered demand, utilization and expenditures for long term care services. The contractor will also develop methodologies for examining the impact of those changes. Their report is expected in June 1985.

During Fiscal Year 1984, the first year of implementation of the prospective payment system, there was a very small (1 percent) increase in SNF admission notices processed by HCFA.

3. Q. There seems to be a great deal of confusion as to how SNFs are being reimbursed today. Can you tell us what payment methodology is being used? Are separate rates being paid to hospital-based facilities?

A. SNFs are reimbursed under Medicare for the "reasonable cost" of services furnished to Medicare beneficiaries rather than being paid on a rate basis. "Reasonable cost" of an individual provider is determined on a retrospective basis. Estimates of the reasonable cost of services are paid to SNFs during their fiscal year and retroactive adjustments are made at year-end based on a cost report submitted by the facility. While there are generally no limitations on the reasonable cost of ancillary services provided by a SNF, there is a limitation on the amount that Medicare will reimburse for the general routine inpatient services, such as room and board and nursing services. However, a SNF may request an exception to this limitation when additional costs are incurred for circumstances beyond its control or as the result of the atypical needs of its patients.

Separate routine cost limitations are being applied to freestanding and hospital-based facilities based on the costs of each group. However, under regulations to be issued for cost reporting periods starting on or after July 1, 1984 the routine limits for hospital-based facilities will be equal to the freestanding facilities limit plus 50 percent of the difference between the freestanding limit and 112 percent of the mean per diem routine rate of hospital-based facilities for urban and rural areas respectively. Hospital-based facility limitations will also include an "add-on" amount to recognize excess overhead allocations resulting from the Medicare principles of reimbursement.

4. Q. Though clearly a very small part of the solution to the access question, can you tell us what is taking place with respect to the swing-bed provisions which allow small rural hospitals to temporarily utilize their acute care beds to provide skilled nursing home care? The program is quite popular in Kansas as you know.

A. In rural areas, the swing-bed provision allows small hospitals to provide long term SNF care in their acute care beds. There continues to be a high rate of growth in hospitals receiving swing-bed approval. As of April 15, 1985, 472 hospitals have been approved for swing-bed services. This should serve to ease access problems in rural areas.

5. Q. Given what I understand to be your interest and ours in a prospective payment system, what is the next obvious step for us to take? Are there administrative steps you could take? Are there models we could test out nationwide?

A. We agree that the current retrospective payment system for skilled nursing facilities (SNFs) is unsatisfactory. This system does not encourage nursing homes to admit Medicare beneficiaries who have heavy care needs, lacks financial incentives for providers to control costs, requires excessive reporting, and creates financial uncertainty by adjusting payment retrospectively. A well designed prospective payment system should overcome these problems.

Our research shows that Medicare SNF patients are significantly different from other SNF patients in that they appear to have more severe medical problems and are more independent in the activities of daily living than the general nursing home patient. Our research also shows that resource use in a nursing home is strongly related to patient care needs. Therefore, we have undertaken a number of studies to develop a case-mix classification system that will measure the resource use attributable to different Medicare patient characteristics. These studies are being conducted by Yale and Rensselaer Polytechnic Institute to develop patient classification groupings based on earlier work at Yale which produced the Resource Utilization Groups (RUGs) classification system. However, the successful development of case-mix resources for Medicare SNF patients is only the first step in developing a prospective payment system. We must also develop systems to collect the necessary data to be used in computing the payment rates.

We currently are conducting Medicaid demonstrations in New York and Texas using the RUGs classification system as a basis for a prospective payment system. While the purpose of these demonstrations is to design Medicaid nursing home payment systems, both States will be collecting data on facilities with high Medicare utilization. Data from these demonstrations will be used to study different approaches to prospective payment for Medicare SNF patients.

While we proceed with these research efforts, we are also studying the possibility of developing a payment system that combines the hospital prospective payment and the payments for Medicare-covered SNF and home health care. Under such an approach the hospital would contract and pay for nursing home and home health services on the patient's behalf, and would assume the responsibility for managing the entire episode of care. Such a system would give the hospital a financial stake in the efficient use of all acute care services. We are currently funding a contract with the Rand Corporation to study the feasibility of this approach. During the next several months, Rand will develop the necessary data bases that link the hospital and post-hospital

episodes of care and carry out analyses that will enable us to decide how to best design a demonstration and set the rates for payment. We expect to make initial payment under such a demonstration by fall 1986.

We have also included in our recent grant announcement a priority area for demonstration programs to test alternative financing for long term care, including patient-related or case-mixed based prospective payment systems.

I'm sure you will agree that the complexity of the problem is such that we must avoid premature solutions that may result in more cost, burden or access problems than under our present cost reimbursement system. We believe that we are on the right track to finding suitable alternatives that are compatible with our mutual goals for reform.

6. Q. Among our witnesses today is Dr. Willging, representing the American Health Care Association. He will be presenting a plan proposed to alleviate a number of deficiencies identified in the current skilled nursing facility benefit. Theirs is a transitional plan designed to move us toward a prospective payment model. Are you aware of their proposal and, if so, could you please comment on your impressions of the plan.

A. We are currently conducting analyses to estimate the impact of the AHCA proposal. Our preliminary evaluation of the plan is that the overall approach proposed of an individual, facility-based reimbursement system does not address many of the issues we would need to see in a prospective payment system, such as incentives to admit heavy-care patients.

7. Q. What is being done, if anything, to ease the reporting burden?

A. HCFA is considering several ways to address this concern. One approach would be a revision to the SNF cost report to reduce the number of data entries presently on the cost report. Another approach is the transfer of data using electronic media such as magnetic tape or direct data transfer. This would eliminate the need to prepare voluminous hard copy cost reports.

8. Q. Have you contracted out for any studies to monitor quality of care in skilled nursing facilities?

   A. The Health Care Financing Administration is currently funding three projects which have as their focus improvement of the procedures for reviewing quality of care in nursing homes. A New York State project tests the simplification of the periodic medical review/independent professional review processes in nursing homes, and combines the process with the annual facility survey. Surveyors use 11 sentinel health events (SHE), such as accidents, decubitus ulcers, and medication regimen to determine if nursing home patients are receiving quality care. Facilities found to have fewer than average problems in these areas receive a less than full facility survey. A Massachusetts project uses statistical quality control techniques to determine appropriateness of care and placement without review of all Medicaid patients. The third study, conducted by Mathematica Policy Research, evaluates the New York and Massachusetts demonstrations and an earlier demonstration in Wisconsin. A draft final report is under review and should be available in the near future.

9. Q. The draft report indicates that 35 percent of skilled nursing facilities are at the limits of reimbursement. Do we know what kinds of facilities these are? Are they hospital-based, freestanding, urban, rural? How many of the 400 skilled nursing facilities providing the majority of skilled nursing facility care are at the payment limits?

   A. Under the DEFRA cost limits, which will be effective retroactively to July 1, 1984, 48 percent of urban hospital-based facilities and 35.9 percent of rural hospital-based facilities were at the payment limits as compared to 22.9 percent of urban freestanding and 23.2 percent of rural freestanding facilities. We have no information available on the percent of facilities at the payment limits by volume of Medicare services provided.

10. Q. How has the phenomenon of "reaching the limit" affected skilled nursing facility participation? Do they reach the limit right away? Then drop out? Or do they continue?

   A. We have no information that would suggest that facilities at the limits have dropped out of Medicare. Some facilities that provide special services at high cost (e.g., very intensive rehabilitative services to a specialized clientele) have applied for and been granted exemptions to the cost limits.

11. Q. Were we to put into place a prospective system, how do you imagine that we could monitor and assure quality of care in skilled nursing facilities?

A. HCFA does not envision that special quality assurance monitoring in addition to the current survey and certification processes would be necessary. If we were to implement a SNF prospective payment system with casemix adjusted payments, such a payment methodology should provide financial incentives to provide better quality care to heavy care patients than the current payment system.

12. Q. To what extent are outliers a function of a lack of SNF beds?

A. We do not know. Under the current law, we consider inpatient hospital care to be medically necessary when a hospitalized patient requires transfer to SNF care and a SNF bed is not available. Such days have always been treated as inpatient hospital days and have never been reported separately. Under the prospective payment system, the cost of these days was included in the base.

13. Q. How common are retrospective denials in SNF reimbursement?

A. Currently, review of SNF claims is done by the intermediaries on a retrospective basis and virtually all SNF denials occur after the care has been rendered. SNFs themselves, however, usually evaluate a Medicare patient's condition carefully before admission to determine whether the patient's condition and the level of care required will warrant Medicare payment. When it does not appear that covered care is required, the SNFs advise the patient accordingly. Thus, although the claims denials are retrospective, patients are generally forewarned as to the ultimate disposition of their claims.

14. Q. To what do you attribute the enormous disparity in the availability of skilled nursing home beds from State to State?

A. We believe that this disparity is principally due to the strong influence of State Medicaid programs in shaping the kinds of nursing home services available in a State. In many of the States with low Medicare SNF bed availability and/or low rates of use of the Medicare SNF benefit, the State Medicaid program is heavily oriented (over 80 percent) toward ICF-level care. Because Medicare represents only 2 percent of nursing home financing nationally, whereas Medicaid represents 48 percent, facilities have fewer incentives to offer SNF services in States where the great majority of Medicaid patients are certified at the ICF-level of care. Conversely more Medicare certified SNF beds and higher use of the Medicare SNF benefit tend to characterize States where there are greater numbers of Medicaid SNF patients.

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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE
UNITED STATES SENATE
ON
PROSPECTIVE PRICING FOR SKILLED NURSING FACILITIES

April 17, 1985

The American Hospital Association (AHA), on behalf of its more than 6,100 member hospitals and health care institutions that annually provide services to more than 10 million Medicare beneficiaries, welcomes this opportunity to express its views on reform of Medicare payment for skilled nursing facility (SNF) services. The past two years have seen major changes in the financing of health services, both in the Medicare program and in the private sector. The unifying theme of these changes has been reliance on financial incentives to motivate changes in the organization, delivery, and production of health services. The response to these changes has been overwhelmingly positive, but tempered by a concern with the longer-term consequences of some of the specific policies that have been implemented. Within the Medicare program, the Association is currently looking for ways of bringing to completion the reforms that were initiated by the adoption of the prospective pricing system

for inpatient acute care services. The goal of further reforms must be the creation of a system of mutually reinforcing incentives that will assure the availability and delivery of needed services to Medicare beneficiaries. Such incentives should foster the use of appropriate levels of care and delivery settings, and should reward hospitals and other providers adequately and fairly for the appropriate and efficient use of health resources.

The next developmental step is likely to be more difficult than the first for several reasons. First, we know considerably less about the non-acute care services covered by the Medicare benefit. These services reflect very different patterns of utilization than do acute inpatient services and, as noted in the study of the Health Care Financing Administration (HCFA), these utilization patterns are poorly understood. Little research and demonstration activity involving these services has been conducted, leaving large gaps in our understanding of the consequences of alternative financing arrangements. In fact, we are just now reaching the point of knowing the correct questions to ask in developing alternatives to current financing policies.

The second barrier to the development of responsible reform proposals is the complex--and poorly defined--nature of "long-term care" services and the "long-term care" delivery system. Long-term care includes a wide range of services, only some of which are covered by Medicare. While hospital services can be defined by the fact that they are provided in hospitals, long-term care services are often defined, mistakenly, as all services <u>not</u> provided in a hospital. The vast majority of hospital services do fall within the scope of

the Medicare benefit, but the majority of long-term care services are not covered by Medicare. Further complicating the picture, long-term care services are often--and mistakenly--viewed as substitutes for one another or for other types of services. The major challenge in the area of long-term care is the development of mechanisms that:

- promote the efficient production of services while recognizing legitimate differences in the costs of services of different providers;
- promote both the appropriate use of various settings and providers; and
- promote the coordination of care across settings and providers.

Finally, the goals of long-term care are somewhat different, and more diverse, than the goals of inpatient acute treatment. By its nature, acute care tends to be episodic and to have as its goal the prevention of long-term injury or death. Long-term care may have many different goals: recuperation, rehabilitation, or long-term maintenance. These goals are not the exclusive province of long-term care providers, but they may serve to distinguish the various types of providers of long-term care services. Any reform in the financing system must recognize these differences.

The effort to reform the financing of long-term care services will be neither simple nor quick because the issues are many and complex. A "quick fix" to reduce Medicare expenditures is likely to create as many problems as it

solves. A financing system is needed that minimizes the total per capita cost of Medicare covered services while maximizing the well-being and independence of Medicare beneficiaries. Such a goal can be achieved only if the payment system assures the availability of the services needed by Medicare beneficiaries.

POLICY QUESTIONS

The study on the Medicare skilled nursing benefit, recently completed by HCFA, provides a wealth of information. Even more importantly, the report highlights the extent to which current knowledge is insufficient to support a major reform of either the skilled nursing benefit or skilled nursing payment policies. The key findings of the report are:

- The availability of skilled nursing beds varies widely across states.

- The use of skilled nursing services also varies widely. In fact, the variation in the use of skilled nursing services is by far greater than the variation in the use of hospital services.

- The cost of skilled nursing services also varies widely, in large measure in response to differences in the types of patients treated in different facilities. However, factors determining the need for skilled nursing services are not the same as factors determining the need for or cost of acute hospital services. Most importantly, there are no widely accepted, validated measures of hospital case mix that can be used as the basis for a payment system.

- Much of the difference between hospital-based and freestanding skilled nursing facilities is attributable to differences in case mix.

- The criteria for approval of skilled nursing benefits also vary widely across regions, demonstrating the absence of uniform, widely accepted indicators for use of skilled nursing services.

The HCFA report was not intended to serve as the basis for a prospective pricing system for skilled nursing services. However, several statements and omissions in the report merit comment as they highlight the questions that must be answered before any further reform of the skilled nursing payment system is undertaken.

First, the report does not explicitly address the differentiation of various types of long-term care services. In fact, at several points, the report appears to further blur the distinction between acute and long-term services. Specifically, the report makes reference to "skilled nursing and rehabilitation services," without distingushing between the rehabilitation services provided in SNFs and the rehabilitation services provided in rehabilitation hospitals and rehabilitation units of general hospitals. It is important to recognize that patients in need of intensive rehabilitation services are treated in acute hospitals and that these services are covered under the hospital, and not the skilled nursing, Medicare benefit. An important question that also needs to be addressed is the feasibility and

advisability of prospective pricing for rehabilitation services. Consequently, this issue should be kept separate from the discussion of a skilled nursing prospective pricing system. One of the important issues to be addressed during this discussion, however, is how the two types of services should relate to one another.

Second, the report devotes considerable attention to the question of case-mix differences among SNFs and the extent to which such differences account for differences in costs among facilities. This is an extremely critical question, and one that is still largely unanswered. Considerable progress has been made in the development of our understanding of case-mix differences among skilled nursing patients, but research has not, to date, yielded a case-mix system that might serve as the basis for a prospective pricing system. Because any case-mix system for skilled nursing services will be experimental, any such system must be thoroughly tested before it is actually used as part of Medicare prospective pricing.

The report primarily approaches the question of case-mix adjustment from the perspective of the ability of any system to distinguish among different facilities. An equally important, but unexplored, question is the ability of a case-mix system to yield a stable stream of revenue which is matched to the costs incurred by a facility in treating its Medicare patients. Research addressing the volatility of SNF case mix is essential before adoption of a prospective pricing system for skilled nursing services. Of particular interest is the extent to which any case-mix system recognizes the prevalence

of outlier cases--or patients requiring more care than the average patient in a given diagnostic category--in skilled nursing facilities.

Another area that is inadequately dealt with in the report is the important function performed by swing beds. The swing-bed program was created as a means of efficiently meeting the skilled nursing needs of patients in rural communities in which SNFs are in short supply. The swing-bed program primarily address the need for relatively brief long-term care by patients recuperating from acute illnesses. AHA is committed to this program, believing it is performing an increasingly valuable function in the current Medicare financing system. Any effort to reform the skilled nursing benefit or payment system must give explicit attention to the special needs of these facilities and the patients they treat.

Finally, the report does not discuss distortions in estimates of the cost of skilled nursing services that may be created by traditional Medicare cost-finding techniques. Throughout the report, the potential benefits of prospective pricing are emphasized, without acknowledging that the realization of these benefits is dependent both upon a system that accurately recognizes differences in the types of patients admitted to SNFs and upon a system that adequately compensates providers for the cost of the services actually used by skilled nursing patients. Equally important, the report focuses on differences in the per-case or per-day cost of skilled nursing services, without looking at the per-capita cost of services used by the skilled nursing population. The per-capita measure, when combined with indicators of patient

well-being and independence, may be the more important indicator of the adequacy of Medicare's payment and benefit policies.

CONCLUSION

The issues raised by this hearing and addressed in the first phase of the HCFA report on the skilled nursing benefit are extremely important. Considerable time and effort have already gone into understanding the use and cost of skilled nursing services. It is easy to become impatient with both the pace of the required research and the inadequate level of our knowledge. However, it is critical that a firm basis be developed for any changes in policy, because the impacts of fundamental reforms will be felt for many years. The type of research that is necessary extends well beyond the economic analysis of cost differences. It must include alternative methods of delivering services to the Medicare population, particularly the frail elderly who are most likely to need long-term care. Hospicals have been active in developing such innovative programs, and hospital interest in these activities continues to grow. The AHA is prepared to work with the Subcommittee and the Department of Health and Human Services to facilitate the search for a system to promote the efficient and effective delivery of care to the Medicare population.

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STATEMENT OF

SOUTHWEST FEDERATION OF HEALTH CARE ASSOCIATIONS

TO THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

APRIL 17, 1985

subject: Medicare payment for
Skilled Nursing Facility
Services

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to share our views with the Finance Committee relative to the need to significantly improve access to Medicare skilled nursing facility benefits.

The Southwest Federation of Health Care Associations is a regional organization of some 800 nursing homes in the states of Louisiana, Arkansas, and Oklahoma which serve 65,000 elderly patients daily.

The overwhelming majority of these institutions are privately-owned intermediate care facilities (ICFs) serving Medicaid-supported and private paying residents. The predominance of ICFs reflects the fact that the Medicaid programs in each of the three states have emphasized that level of care to the virtual exclusion of high intensity, shorter term skilled nursing services. At the same time, however, it must be noted that such an emphasis by the states is partly, perhaps greatly, influenced by the relative absence of nursing homes that have been willing to become certified as SNFs to participate in Medicare.

BACKGROUND

The present concern of the Committee over the lack of Medicare SNF services is not new. Indeed, in 1978, a member of the Committee, Sen. Gaylord Nelson, sought to address the problem directly by simply compelling SNFs to participate in Medicare as a condition of accepting Medicaid patients. The nursing home industry understandably opposed the Nelson amendment as a simplistic and coercive measure that ignored the

underlying reasons why few nursing homes have opted to take Medicare patients. Sen. Nelson ultimately withdrew his own amendment on the floor in favor of a 6-month study when it became clear that an amendment filed by Sen. Richard Schweiker to delete the mandatory participation provision was likely to be adopted. Sen. Schweiker's observations on the Nelson amendment remain instructive:

> "Mr. President, from all indications the reason for declining participation (by skilled nursing facilities) in Medicare ... is unmanageable paperwork, slow collection on claims, and a host of other administrative difficulties relating to red tape and bureaucratic inconvenience. It seems to me that it would be far more effective to aim reform efforts directly at those problems rather than try to coerce SNF participation with this kind of all-or-nothing condition. Because these deterrents to participation will not be removed by the amendment, I also doubt that it will work. My amendment would delete this new provision in hopes that a more constructive approach to the problem can be found."
>
> Hon. Richard Schweiker
> Congressional Record, 9/11/78
> S14906

Unfortunately, Mr. Chairman, Sen. Schweiker's hopes for a more constructive approach have not been realized, and the access problems properly identified by Sen. Nelson have become more pervasive and will continue as long as the root causes are not dealt with.

Prior to the advent of the hospital prospective payment system, Medicare could spend its way around this problem by simply allowing patients to stay on in hospitals when an alternate placement could not be found. That option is no longer available. If the DRG program is to work properly, skilled nursing facility, home health, and other post-hospital placement options must be provided.

In the case of skilled nursing facility services, no real solution is possible that does not directly address the need to reform the payment system. The Southwest Federation views this matter as one of increasingly urgent priority. Happily, we are persuaded that a simple and straightforward reform of Medicare payment policy can be enacted and implemented in a reasonably short period of time. Though the failure of HCFA to provide the Congress with specific recommendations for payment reform as required by the Deficit Reduction Act of 1984 is regrettable, this failure need not prevent the Finance Committee from moving forward.

We are mystified that the Administration seems content to deny the existence of a problem that HCFA's own recent report so clearly illustrates. To say that Medicare services are adequately available except in certain isolated pockets of the United States flies in the face of HCFA's findings, and consigns entire states such as Arkansas, Louisiana, Oklahoma, Texas, Montana, Kansas, Oregon, and Minnesota to the category of "isolated pockets." Mr. Chairman, the fact that Medicare SNF services appear to be widely available in New York and California and in some urban areas elsewhere does not make for a national program.

In a similar vien, though we understand the desire of HCFA and other students of long term care to develop at some future date a payment system that is scientifically related to individual variations in patient care needs, we are quite sure that such an "ideal system" is many years off at best, and there is no guarantee that a case-mix methodology will not be so impractical to administer as to be self-defeating. Thus, we

cannot join those who counsel inaction in the face of clear evidence that the present Medicare system is seriously flawed, especially when concrete improvements can be made now. Let research continue, but not at the expense of a continuing denial of Medicare benefits to those elderly patients who need and are entitled to receive them.

SPECIFIC RECOMMENDATIONS FOR PAYMENT REFORM

The Federation recommends that the Committee take as its starting point the twin realities that (1) most SNFs now in the Medicare program provide relatively few annual Medicare-covered patient days, and (2) the same is likely to be true for new SNFs that could be induced to enter the Medicare program in those geographic areas where the need is most critical.

It would seem, therefore, that an uncomplicated prospective pricing system for low volume Medicare SNFs is a logical first step that could be implemented with minimum administrative effort and would have a high probability of success in providing enhanced access relatively quickly. The information necessary to estabish initial per diem prices is readily available to HCFA in the form of data that is continuously generated through the §223 cost limit procedures. This data is broken down on a SMSA and non-SMSA basis, and contains local wage adjustement factors and a market basket index for SNF services. Data is also available to estabish standard prices for ancillary services which, because they are not routinely used by all patients, must be billed separately as under the current system.

The Federation strongly urges the Committee to legislate, at a minimum, a low volume optional standard payment provision that sets fixed rates for routine services on a geographic basis.

We are aware of and support additional recommendations presented to the Committee by the American Health Care Association that would also establish a prospective payment method for higher volume Medicare SNFs on a facility-by-facility basis subject to geographic ceilings. The AHCA proposal seeks the cost containment incentives of prospective rate-setting while ensuring equitable treatment of providers with variable cost structures and patient mix, a consideration which becomes more important as Medicare volume increases.

We commend the Committee for its interest in this area of Medicare program reform and urge you to translate that interest into specific legislation during the current legislative session.

Bruce D. Thevenot
Director
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